



## GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) BOARD MEETING AGENDA

### *State of California* DEPARTMENT OF HEALTH CARE SERVICES

Notice is hereby given that the **Global Medi-Cal DUR Board** will conduct a public meeting on **Tuesday, May 21, 2019**, at the following location:

Department of Health Care Services  
1700 K Street  
1<sup>st</sup> Floor Conference Room  
Sacramento, CA 95814  
9:30 AM-3:00 PM

All times shown are approximate and are subject to change  
[Registration link](#) to attend meeting via webinar

Report Type*	Agenda Item	Presenter	Time
C	1. Welcome/Introductions/Roll Call	Pauline Chan, RPh, MBA	930-940
I/D	2. Call to Order/Guidelines	Randall Stafford, MD, PhD	940-945
R/A/D	3. Review and Approval of Previous Minutes from February 26, 2019	Randall Stafford, MD, PhD	945-950
	4. Old Business		
I/D	a. Review of Board Action Items from February 26, 2019 b. Recommended Action Items for MCPs from February 26, 2019	Pauline Chan, RPh, MBA	950-1010
	5. New Business		
A/D	a. DUR Board Activities i. Summary of MCO Best Practices	Randall Stafford, MD, PhD	1010-1050
Morning Break			1050-1055
R/D	b. Health Plan Presentation: "The Safe Choice Program: A Response to the Opiate Crisis"	Beth Stewart, MD and Nick Osterman, MA, LMFT [Anthem Blue Cross]	1055-1140
R/A/D	c. DUR Annual Report to CMS: FFY 2018 MCO Summary	Pauline Chan, RPh, MBA	1140-1230
Lunch Break			1230-130
R/D	d. Recap of morning action items	Hannah Orozco, PharmD	130-135
R/A/D	e. Retrospective DUR i. Global Annual Report: FFY 2018 ii. FFS Quarterly Report: 1Q2019 (Jan – Mar 2019) iii. Biennial Report 2018: Part II	Amanda Fingado, MPH	135-210

R/A/D	<ul style="list-style-type: none"> <li>iv. Review: Gabapentinoids</li> <li><b>f. Review of DUR Publications</b> <ul style="list-style-type: none"> <li>i. Bulletin (February 2019): MEDD Updates</li> <li>ii. Alert (March 2019): Fluoroquinolones</li> <li>iii. Alert (April 2019): Sudden Discontinuation of Opioids</li> <li>iv. Discussion/Recommendations for Future Bulletins</li> </ul> </li> </ul>	Shalini Lynch, PharmD	210-225
R/A/D	<ul style="list-style-type: none"> <li><b>g. Prospective DUR: Fee-for-Service</b> <ul style="list-style-type: none"> <li>i. New GCNs for 1Q2019 (Jan – Mar 2019)</li> <li>ii. Update: AT Alert and Gabapentinoids</li> </ul> </li> <li><b>h. DUR Educational Outreach to Providers: Fee-for-Service</b> <ul style="list-style-type: none"> <li>i. Proposal: Zolpidem</li> <li>ii. Proposal: Opioids in Children &lt; 18</li> <li>iii. Outcomes: MEDD – 2019</li> </ul> </li> </ul>	Amanda Fingado, MPH	225-230
R/I//D	<ul style="list-style-type: none"> <li><b>i. Pharmacy Update</b> <ul style="list-style-type: none"> <li>i. Policy: AB1114 Implementation</li> <li>ii. DUR goals, priority areas, and related measures</li> <li>iii. Opioids Safety Toolkit for Health Plans</li> <li>iv. CURES 2.0</li> <li>v. Academic Detailing</li> <li>vi. Addressing Complex Drug Regimens</li> <li>vii. SUPPORT Act</li> <li>viii. FFY 2018 DUR Annual Report</li> </ul> </li> </ul>	Pauline Chan, RPh, MBA	230-245
R/D	<ul style="list-style-type: none"> <li><b>j. Recap of afternoon action items</b></li> <li><b>k. Looking ahead: Call for future meeting agenda topics</b> <ul style="list-style-type: none"> <li>i. Presentation by Linette Scott, MD, MPH on Core Set Measures</li> <li>ii. Presentation by Sharon Cummins, PhD and Neal Kohatsu, MD, MPH: “Tobacco Quitlines, Incentives and the Medicaid Population”</li> </ul> </li> </ul>	Hannah Orozco, PharmD	245-250
C	<b>6. Public Comments **</b>		250-300
I	<b>7. Consent Agenda</b>		
	<ul style="list-style-type: none"> <li><b>a. Meeting feedback</b></li> <li><b>b. Next meeting: September 17, 2019</b> 1700 K Street 1<sup>st</sup> Floor Conference Room Sacramento, CA 95814</li> <li><b>c. Proposed DUR Board Meeting Dates for 2019/2020:</b> Tuesday, November 19, 2019 Tuesday, March 3, 2020 Tuesday, May 19, 2020 Tuesday, September 15, 2020 Tuesday, November 17, 2020</li> </ul>		
	<b>8. Adjournment</b>		300

\* REPORT TYPE LEGEND: **A: Action; C: Comment; D: Discussion; I: Information; R: Report**

\*\* Comments from the public are always appreciated. However, comments will be limited to five minutes per individual.

Picture identification is required to gain access into the California Department of Health Services building. However, your security information will not be provided to the Global DUR Board.

You can obtain the Global DUR Board agenda from the Medi-Cal DUR Main Menu Web site ([http://files.medi-cal.ca.gov/pubsdoco/dur/dur\\_home.asp](http://files.medi-cal.ca.gov/pubsdoco/dur/dur_home.asp)).



**GLOBAL MEDI-CAL DUR BOARD MEETING  
PACKET SUMMARY  
May 21, 2019**

- **Suggested Sections to Review Prior to Meeting:**
  - DUR Annual Report to CMS: FFY 2018 MCO Summary (**Pages 19 – 37**)
    - This summary highlights selected portions of the DUR annual report and includes data from all 26 Medi-Cal managed care plan submissions. This first annual summary is modeled after the state-by-state comparison presented each year to the Board. Data are presented in aggregate and do not contain plan-specific information.
  - Global Annual Report: 2018 (**Pages 48 – 53**)
    - Pharmacy utilization data is being reported from claims processed through both the fee-for-service and managed care systems for calendar year 2018. Review this report in advance of the meeting and be prepared with questions and comments.
- **Important Reminders**
  - The following tentative dates for the 2019 DUR Board meetings have posted:
    - Tuesday, September 17, 2019
    - Tuesday, November 19, 2019

## Global Medi-Cal DUR Board General Meeting Guidelines

- Be familiar with the [Bagley-Keene Open Meeting Act](#)
- Be familiar with [Robert's Rules of Order](#)
- Be courteous, respectful, and open minded of other's comments
- Be prepared by reviewing materials and downloading documents on PC/tablet in advance





**GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) BOARD  
MEETING MINUTES**

**Tuesday, February 26, 2019**

9:30 a.m. – 3:00 p.m.

**Location: Department of Health Care Services (DHCS)  
1700 K Street, 1<sup>st</sup> Floor Conference Room  
Sacramento, CA 95814**

Topic	Discussion
<b>1) WELCOME/ INTRODUCTIONS</b>	<ul style="list-style-type: none"> <li>The Global Medi-Cal Drug Use Review Board (the "Board") members and meeting attendees introduced themselves.</li> <li>Board members present: Drs. Timothy Albertson, Michael Blatt, Chris Chan, Lakshmi Dhanvanthari, Jose Dryjanski, Stan Leung, Johanna Liu, Janeen McBride, Robert Mowers, Yana Paulson, Randall Stafford, Marilyn Stebbins, Vic Walker, Andrew Wong, and Ramiro Zuniga.</li> <li>Board members absent: none.</li> <li>DHCS staff present included Pauline Chan, RPh, David Do, PharmD, Paul Nguyen, PharmD, Ivana Thompson, PharmD, and Jose Villalobos, MPA. Dorothy Uzoh, PharmD and Teri Miller, PharmD attended the meeting via webinar.</li> <li>Representatives present from other Medi-Cal managed care plans (MCPs) attending in-person included Nina Duong, PharmD (Inland Empire Health Plan), Adam Horn, PharmD (CenCal Health), Ed Jai, PharmD (Inland Empire Health Plan), Amit Khurana, PharmD (Aetna Better Health of California), Susan Nakahiro, PharmD (Kaiser), Jessica Shost, PharmD (San Francisco Health Plan), and Flora Siao, PharmD (California Health &amp; Wellness).</li> <li>Representatives present from other Medi-Cal managed care plans (MCPs) attending via webinar included Barrie Cheung, PharmD (Health Plan of San Mateo), Anthony Dao (AIDS Healthcare Foundation), Kris Gericke, PharmD (CalOptima), Jeff Januska, PharmD (CenCal Health), Diana Khader, PharmD, MBA (CalOptima), NhuAnh Le, PharmD (Health Plan of San Joaquin), Stephanie Lem, PharmD (CenCal Health), Charles Lino, PharmD (Community Health Group), Lynette Rey, PharmD (Partnership Health Plan of California), Ankit Shah, PharmD (UnitedHealthcare Community Plan of California, Inc.), Ming Shen, PharmD (Health Plan of San Mateo), Mimosa Tran, PharmD (Molina Healthcare of California Partner Plan, Inc.), Janet Tsai, PharmD, MBA (L.A. Care Health Plan), Bruce Wearda, RPh (Kern Family Health Care), and Andrew Yau, PharmD (Health Plan of San Mateo).</li> </ul>
<b>2) CALL TO ORDER/ GUIDELINES</b>	<ul style="list-style-type: none"> <li>The Chair of the Board, Dr. Randall Stafford, called the meeting to order. He stated that while the last year was a year of transition to the Global Medi-Cal DUR Board, he looks forward to this being a year of action.</li> <li>Dr. Stafford reviewed the general meeting guidelines and stated that everyone should have the mindset to be courteous, respectful, and open-minded.</li> </ul>
<b>3) MEETING LOGISTICS</b>	<p>Ms. Chan summarized Robert's Rules of Order, including the main motion process. Ms. Chan then presented an overview of logistics for the DUR Board meetings, including the Wi-Fi passcode, seating arrangements, the managed care plan roll call, and the process for making comments. Ms. Chan also encouraged the Board to complete the meeting feedback survey.</p>

<b>4) REVIEW AND APPROVAL OF PREVIOUS MINUTES FROM NOVEMBER 27, 2018</b>	<p>Dr. Stafford stated that he is viewing an electronic copy of the agenda and packet in order to follow the agenda and attachments being presented. He explained that any Board members using personal computing devices during the meeting are viewing the same materials provided to the public. This statement is required by Open Meeting rules.</p> <p>The Board reviewed the minutes from the Board meeting held on November 27, 2018. Dr. Zuniga motioned that the minutes be approved. Dr. Wong stated he had a few minor edits to the minutes and motioned to approve the minutes to include his edits. The motion was seconded. There was no discussion. The Board voted to approve the minutes with Dr. Wong's edits.</p> <p><b>AYE:</b> Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Zuniga  <b>NAY:</b> None  <b>ABSTAIN:</b> None  <b>ABSENT:</b> Albertson, Mowers</p> <p><b>ACTION ITEM:</b> Incorporate Dr. Wong's edits into the November 27, 2018 minutes and post to the DUR website.</p>
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<b>5) OLD BUSINESS</b>	<p><b>a.</b> Review of Board Action Items from November 27, 2018:</p> <ul style="list-style-type: none"> <li>i. Update bylaws to include election process details – Ms. Chan stated that the election process has been approved. However, the bylaws do not need modification at this time.</li> <li>ii. Candidates for vice chair to submit statement of interest to DHCS by August 1 (for September elections) – Ms. Chan stated that this process has been approved and reminders will be sent to the Board before the deadline.</li> <li>iii. Update Board priorities to move three subtopics under “Optimizing Biologics, Specialty Drugs, and Cost-effective Care” to “Optimizing Drug Prescribing and Dispensing” – Ms. Chan stated this has been approved and the edits have been incorporated into the Board priority slides that will be discussed later today.</li> <li>iv. DHCS to follow Medicare policy on automatic refill – Ms. Chan stated that the Board recommendation is under consideration by DHCS.</li> <li>v. Updates to standard data reports for Board meetings – Ms. Chan stated that these updates have been approved and two of the new reports proposed will be presented today. Ms. Fingado stated that while it was proposed to have an annual utilization report of Physician Administered Drugs (PADs) for the entire Medi-Cal program, it was determined that the PADs reports will continue to include Medi-Cal fee-for-service beneficiaries only due to issues with encounter data submissions. The annual review of PADs data is scheduled for presentation at the September DUR Board meeting.</li> </ul> <p><b>b.</b> Recommended Action Items for MCPs from November 27, 2018: Ms. Chan presented the recommended action items for MCPs from the Board meeting held on November 27, 2018. Recommendations are separated into two categories: required action items and suggested action items.</p> <p><b>c.</b> FFS TAR Data (4Q2018): Dr. Nguyen presented the top 32 drugs submitted for <i>Treatment Authorization Request</i> (TAR) during 4Q2018, which includes all requests from October 1, 2018, through December 31, 2018. Dr. Stafford commented that while the TAR process remains a burden, it is his understanding the process has improved. Dr. Stafford noted that many of the medications on the list are safe, important medications and he expressed concern that patients may experience treatment delays for these drugs. Dr. Stebbins suggested that we look at how many TARs are due to the six prescription maximum, and that perhaps it is time to look at this limit again, as it likely affects patients with chronic illness. Dr. Zuniga suggested comparing adherence to insulin pens in comparison to insulin vials. Dr. Thompson stated it is difficult to measure adherence to insulin due to days' supply. Dr. Liu suggested that a future topic for review could be those medications with high (&gt; 80%) approval rates. Dr. Liu suggested maybe some of these drugs could have TAR requirements removed. Dr. Thompson reminded the Board that FFS has a List of Contract Drugs (CDL), not a formulary, and lack of inclusion on the CDL is because there is no</p>
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	<p>contract. Claims for drugs not on the CDL require a TAR. Dr. Dhanvanthari suggested that the reasons for denial of long-acting antipsychotics be reviewed. Dr. Thompson stated that the reasons for denial are not captured by the system FFS uses, but a request can be made to the TAR office for a report on this topic.</p> <p>Dr. Stebbins motioned that the top drugs on the TAR list be reviewed again to identify how many TARs are due to being over the six prescription maximum. The motion was amended to also include the top three reasons for denials among antipsychotic medications. There was no further discussion. The motion passed.</p> <p><b>AYE:</b> Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Stafford, Stebbins, Walker, Wong, Zuniga  <b>NAY:</b> None  <b>ABSTAIN:</b> None  <b>ABSENT:</b> Albertson, Mowers, Paulson</p> <p><b>ACTION ITEM:</b> The DUR Board recommendation to complete an additional review of the TAR drug data to determine the percentage of TARs for each drug that are due to the statutory prescription limit and the top three reasons for denials among antipsychotic medications will be submitted to DHCS.</p>
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<b>6) NEW BUSINESS</b>	<p><b>a. Global DUR Board Activities</b></p> <ol style="list-style-type: none"> <li>i. Annual Review: 2018 – Dr. Wong reviewed the highlights of the first year of the Global Medi-Cal DUR Board, which covered FFY 2018 (October 1, 2017, through September 30, 2018). Dr. Wong stated he was very proud of the successful transition from the fee-for-service DUR program to a Board that now includes representation from managed health care plans. Dr. Wong then read a list of managed care health plans that participated in the Board meetings during 2018. Dr. Wong shared his appreciation and gratitude to these plans for their support and engagement.</li> <li>ii. Board Goals/Priorities: 2019 – Dr. Stafford thanked Dr. Wong for his leadership during FFY 2018, especially his successful facilitation of the DUR program during the first year after the Board expansion. Dr. Stafford then presented the goals for the Global Medi-Cal DUR Board for 2019, which included the following: <ul style="list-style-type: none"> <li>• Advise DHCS regarding the revision of DUR reports to include drugs commonly used in both Medi-Cal Fee-for-Service (FFS) and Managed Care Organizations (MCOs)</li> <li>• Promote dialogue, collaboration among MCOs</li> <li>• Align goals with <a href="#">DHCS Quality Strategy</a></li> <li>• Advise DHCS in the implementation of Medicaid Drug Utilization and Review Minimum Standards for the <a href="#">Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act</a></li> </ul> </li> </ol> <p>Dr. Stafford then began to review the priority area topic clusters and suggested we begin to disseminate best practices for which we have consensus. Dr. Stafford stated that he would like to continue to make an impact within the areas prioritized by the Board. Dr. Stafford acknowledged the DUR program has a long history of dissemination and while bulletins are a tried and true vehicle for dissemination, he proposed continuing to use bulletins and also expanding dissemination to integrate and align with policy. Dr. Stafford also suggested that the review of the TAR program showed that in some ways, the FFS program is lagging behind the MCOs.</p> <p>Dr. Stafford then reminded the Board of the following priority area topic clusters:</p> <ul style="list-style-type: none"> <li>• Optimizing Drug Prescribing and Dispensing, including specialty drugs</li> <li>• Optimizing Pain Management and Opioids</li> <li>• Optimizing Chronic Disease Management, including prevention</li> </ul> <p>Dr. Shost stated that two topics that stand out in the first priority area are filling cancelled prescriptions and polypharmacy, as cancelled prescriptions do not go through</p>
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the EMR and polypharmacy leads to poor adherence. Dr. Leung agreed there might be multiple TARs for some products such as biologics and there may be a need to cancel one TAR so multiple prescriptions for biologics don't get filled. Dr. Stebbins noted the Board goals for 2019 are lofty and suggested we start picking off the topics one by one. Dr. Stebbins motioned the Board review best practices for prior authorization process improvement and strategies to prevent filling prescriptions that are already cancelled. The motion was seconded. Dr. Wong asked if we were able to obtain data on these issues. Ms. Fingado stated she had never looked at either cancelled or denied pharmacy claims data, however she would look into this as it has been identified as a priority. Dr. Stebbins suggested as we tackle each goal the MCOs should report out on their best practices and it would allow us to be able to compare and to learn from one another. Dr. Liu stated that MCOs may have a specialty pharmacy that manages this and she isn't sure if data from the specialty pharmacy can be reconciled with standard prescription management. Dr. Chan proposed that each plan could present what they are doing and any best practices.

Dr. Stebbins motioned that the Board review best practices for prior authorization process improvement and strategies to prevent filling prescriptions that are already cancelled. The motion was seconded. There was no further discussion. The motion passed.

**AYE:** Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Zuniga

**NAY:** None

**ABSTAIN:** None

**ABSENT:** Albertson, Mowers

**ACTION ITEM:** The DUR Board recommendation to review best practices for prior authorization process improvement and strategies to prevent filling prescriptions that are already cancelled will be submitted to DHCS.

Dr. Stafford then suggested a review of the optimizing pain management and opioid priority area topic cluster. Dr. Stafford stated he is interested in tracking naloxone prescriptions, especially given the new state law requiring prescribers to offer a prescription for naloxone. Dr. Stafford also suggested addressing the scrutiny around prescribing opioids for surgery, as there is typically a standard quantity of opioids prescribed and dispensed that often isn't used. Dr. Stafford also stated there is a new generation of surgeons that are now looking at ways to avoid opioids. There has been a great deal of scrutiny in family medicine/internal medicine but surgery has not had focus. Dr. Zuniga stated he would also like to focus on emergency room (ER) utilization and discharge prescriptions, including beneficiaries visiting multiple ERs for the same complaint. Dr. Stebbins asked if CURES captured these prescriptions and Dr. Zuniga stated he is not sure that ER physicians look at CURES if there is no standard process in place and he noted there is a lag in CURES data that would allow multiple claims to go through.

Dr. Zuniga motioned the Board review the use and prescribing of opioids in the emergency department and surgical setting and a review of naloxone prescribing after the implementation of the new legislative requirements in California

**AYE:** Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Zuniga

**NAY:** None

**ABSTAIN:** None

**ABSENT:** Albertson, Mowers

**ACTION ITEM:** The DUR Board recommendation to review the use and prescribing of opioids in the emergency department and surgical setting and a review of naloxone prescribing after the implementation of the new legislative requirements in California will be submitted to DHCS.

- iii. RetroDUR Review Proposal: Antihyperglycemic Medications – Dr. Stafford then reviewed the optimizing chronic disease management priority area topic cluster, and briefly described the proposal submitted to the Board by Dr. Mowers on antihyperglycemic medications. Dr. Zuniga suggested we look at control of blood glucose with pens in comparison to syringes. Dr. Stafford suggested we look more broadly to the medical literature, investigate the availability of data, including an understanding of the limitations. Dr. Stebbins suggested we should be mindful of recent guideline changes as well.

Dr. Stafford stated that in the absence of other suggestions, he proposes we continue to focus on management of high blood pressure. Dr. Stebbins suggested reviewing disparities in high blood pressure management, as some demographics are doing a better job than others. Dr. Stebbins suggested reviewing adherence data by county or by region. Dr. Wong proposed also choosing at least one preventive topic from the list, such as vaccinations. Dr. Siao also suggested asthma management as a topic, as one of the top three reasons people go to the ER is uncontrolled asthma. Dr. Zuniga suggested an analysis of asthma medications, including the use of controller medications.

Dr. Orozco suggested making these motions narrower as we are looking ahead to the next meeting and what can be accomplished for the next meeting. Dr. Mowers suggested that DHCS collect data on the drug spend on diabetes and referred to his retrospective DUR proposal on antihyperglycemic medications. Ms. Fingado stated that she had spoken with Dr. Mowers about a September timeline for the retrospective DUR review. Dr. Stebbins again suggested that it would be a helpful starting point to add a review of best practices by managed health care plans for all of the suggested topics.

Dr. Mowers made a motion to review diabetes management, hypertension management, asthma management, and immunizations within populations with chronic disease, including a review of best practices among managed health care plans. The motion was seconded. There was no further discussion. The motion passed.

**AYE:** Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Zuniga

**NAY:** None

**ABSTAIN:** None

**ABSENT:** Albertson, Mowers

**ACTION ITEM:** The DUR Board recommendation to review diabetes management, hypertension management, asthma management, and immunizations within populations with chronic disease, including a review of best practices among managed health care plans will be submitted to DHCS.

- b. Health Plan Presentation: Pharmacy Pay-for-Performance (P4P) Program – Doan Trang (Nina) T. Duong, PharmD, a Clinical Pharmacist with the Inland Empire Health Plan (IEHP), provided an overview of an outreach campaign implemented at IEHP that encouraged providers, pharmacists, and members to work together on medication safety. Dr. Duong stated that providers were educated on the role of pharmacists in medication review, members were educated on ways to engage with the pharmacist, and pharmacists were trained in areas that included discussing DUR with providers and members.

Dr. Duong then summarized outcomes from Q1 and Q2 of 2018, noting that the DUR categories that were studied included therapeutic duplication, high dose, drug-drug interaction, and high-risk medication for the elderly, all of which were a hard block and required the pharmacist to conduct a comprehensive medication review and enter a code before the filling or cancellation process could continue. She stated that the P4P program only paid for the codes R0 (history reviewed), M0 (prescriber consulted), and SW (literature search). Dr. Duong reported that in the beginning, there was a decrease in the number of processed claims and in the number of DUR overrides, but that the downward trend did not

sustain. Dr. Duong noted that the average DUR override rate was 56%, with the greatest override rate observed with drug-drug interaction and high-risk medications in the elderly alerts.

Dr. Paulson asked if they had looked at what happened when a patient didn't get a prescription filled. Dr. Duong stated they had not drilled down to that level, as there are over 450 pharmacies. Dr. Khurana asked if they were able to demonstrate an increase in quality or tie data into quality measures. Dr. Duong reported that they do have a customer satisfaction survey. Dr. Shost asked if anyone was grandfathered in, such as patients who were already on high doses of opioids. Dr. Duong stated that high dose was one of the categories set by First Databank, Inc. and there was not a grandfather process.

Dr. Duong then described the pharmacy report card provided to pharmacies and discussed how the results shown in the report card played a role in the P4P program. She shared that payment was provided for interventions, text messaging, customer satisfaction surveys, and a bonus payment was available for pharmacies that met the requirements for bonus eligibility. Dr. Duong stated that the total payout to pharmacies was over \$4 million, with the majority (83%) going towards chain pharmacies. Dr. Duong then covered per member per month savings, cost avoidance, and estimated cost avoidance of adverse drug events and summarized the text-messaging program and customer satisfaction survey. Dr. Jai, the Senior Director and Chief Pharmacist at IEHP, joined Dr. Duong to discuss the current and future aspects of measuring and reporting for the P4P program.

**c. DUR Annual Report to CMS**

- i. FFY 2017: State Comparison Summary – Ms. Chan stated that the full [State Comparison/Summary Report FFY 2017](#) is available on the Centers for Medicare & Medicaid Services (CMS) website and she encouraged everyone to review the summary included in the packet.
- ii. FFY 2018: Fee-for-Service Draft Annual Report – Ms. Chan and Dr. Orozco provided a brief overview of the annual report covering the Medi-Cal fee-for-service program. Ms. Chan stated that the level of detail in the fee-for-service report could be used as a model for how managed care plans should complete their report. Dr. Shost asked how managed care plans should handle carved-out drugs. Ms. Chan stated that managed care plans should just indicate that these drugs are carved out for their plan.

Dr. Stafford motioned to approve the FFY 2018 DUR Annual Report to CMS. The motion was seconded. There was no further discussion. The motion passed.

**AYE:** Albertson, Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Walker, Wong, Zuniga

**NAY:** None

**ABSTAIN:** None

**ABSENT:** None

**ACTION ITEM:** The DUR Board recommendation to approve the FFY 2018 DUR Annual Report to CMS for the Medi-Cal Fee-for-Service program will be submitted to DHCS.

- iii. FFY 2018: Fee-for-Service Additional Data – Ms. Fingado presented data for FFY 2018 that she thought the Board might find useful, but was not required by CMS as a part of the FFY 2018 annual report. Data reported included fee-for-service pharmacy utilization by age group, the top 20 drug therapeutic categories by utilizing beneficiaries, the top 20 drugs by utilizing beneficiaries, and trends over time in generic utilization, generic expenditures, and DUR cost-savings estimates.

Dr. Paulson stated that the generic utilization percentage looks low. Ms. Fingado explained that this is representative of the drugs are covered through fee-for-service, as the carved-out drugs are mostly single source. Dr. Paulson asked if the generic utilization could be stratified to include only the drugs used by fee-for-service enrollees.

Ms. Fingado suggested this would still artificially lower the generic utilization percentage, as the rates reported by managed care plans do not have carved-out drugs included. Ms. Fingado suggested excluding carved-out drugs for fee-for-service enrollees as well. Dr. Stebbins noted that fee-for-service is also mandated to use some branded drugs due to supplemental rebates, which still result in lower costs to the program even though it lowers the generic utilization rate.

Dr. Paulson motioned to calculate generic utilization and expenditure data exclusive of carved out drugs for all FFS beneficiaries and MCPs (by plan) and also for all carved out drugs. The motion was seconded. There was no further discussion. The motion passed.

**AYE:** Albertson, Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Walker, Wong, Zuniga

**NAY:** None

**ABSTAIN:** None

**ABSENT:** None

**ACTION ITEM:** The DUR Board recommendation to present generic utilization and expenditure data exclusive of carved out drugs for all FFS beneficiaries and MCPs (by plan) and also for all carved out drugs.

d. Recap of morning action items – Dr. Orozco and Ms. Fingado read the Board action items from the morning session. Due to technical difficulties, the action items could not be shown on the webinar or projected on the screen in the meeting room. Dr. Stafford expressed concern that some of the details that were discussed had not been included in the action items. Ms. Fingado stated that while the details had been captured as part of the meeting record, the stated action items were intended to be a summary of only one or two sentences.

e. Retrospective DUR

i. Global Quarterly Report 2Q2018 (April – June 2018) – Ms. Fingado presented Ms. Fingado presented the Global Medi-Cal quarterly DUR report for the 2<sup>nd</sup> quarter of 2018. This quarterly report was presented for the first time and contains all pharmacy utilization data for the Medi-Cal program. Utilization data are presented in aggregate, and then stratified by Medi-Cal FFS enrollees only and by Medi-Cal managed care plan (MCP) enrollees only.

Dr. Liu suggested that future reports should have the denominator for the stratified data in Tables 4 and 6 be the total paid claims and utilizing beneficiaries from each program. Ms. Fingado agreed this would improve the clarity of the report and stated she would update the format for future global reports.

Ms. Fingado stated that she plans to re-run the data for this report three months after the initial data pull and evaluate the completeness of the data being presented in this report. Ms. Fingado will report these findings back to the Board in May.

ii. FFS Quarterly Report: 4Q2018 (October – December 2018) – Ms. Fingado presented the Medi-Cal fee-for-service quarterly DUR report for the 4<sup>th</sup> quarter of 2018, which includes both prospective and retrospective DUR data. This quarterly report contains fee-for-service pharmacy utilization data presented in aggregate, and then stratified by Medi-Cal FFS enrollees only and by Medi-Cal managed care plan (MCP) enrollees only. This report includes all carved-out drugs processed through the FFS program.

iii. Biennial Report 2018: Part I – Ms. Fingado presented Part I (of 2) of the biennial report for 2018, which provides detailed evaluations of the following eight DUR educational articles, published between October 2014 and September 2016:

- Clinical Review: Use of Nicotine Replacement Therapy for Smoking Cessation – October 2014

- Alert: Folic Acid Awareness Week is January 4th – 10th, 2015 – December 2014
- Alert: Depression Among Perinatal Women is Overlooked and Undertreated – January 2015
- Improving the Quality of Care: Methotrexate Use and Folate Supplementation – February 2015
- Drug Safety Communication: Varenicline and Alcohol Use – March 2015
- Improving the Quality of Care: Antipsychotic Use in Children and Adolescents – March 2015
- Drug Safety Communication: NSAIDs Increase Chance of Heart Attack or Stroke – August 2015
- 2015 Immunization Updates: Influenza, HPV, MenB, PVC13, and SB 277 – September 2015

The Board agreed with the recommendations in the report and prioritized the retrospective DUR review of NSAIDs among the Medi-Cal population, including an evaluation of those beneficiaries with heart disease or risk factors for developing heart disease. The Board also agreed there was opportunity for collaboration with other state agencies to improve the use of folic acid among female Medi-Cal beneficiaries of childbearing age. Finally, a motion was made to archive the varenicline alert from the DUR website, as the FDA has reversed the boxed warning based on updated data from a clinical trial. The motion was seconded. There was no further discussion. The motion passed.

**AYE:** Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Walker, Wong, Zuniga

**NAY:** None

**ABSTAIN:** Albertson

**ABSENT:** None

**ACTION ITEM:** The DUR Board recommendation to archive the varenicline alert will be submitted to DHCS.

**f. Review of DUR Publications presented by Dr. Lynch**

- Alert (January 2019): Naloxone Legislation – Dr. Lynch let the Board know that the DUR educational alert entitled, “[Alert: New Naloxone Regulations Effective on January 1, 2019](#)” published in January 2019. This alert was a review of Assembly Bill 2760 (Wood, Chapter 324), which requires California prescribers to offer a prescription for either naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid-induced respiratory depression. The alert also provided links to two resources: 1) an FAQ provided on the Medical Board of California website and 2) an article in the December 2018 publication of The Script newsletter on the California State Board of Pharmacy website.
- Discussion/Recommendations for Future Educational Bulletins – The calendar for future DUR educational bulletins was reviewed. Dr. Lynch reviewed the publications in progress. The MEDD update is scheduled to publish this week and Dr. Lynch thanked Dr. Albertson for serving as Board reviewer of this article. A second bulletin on latent tuberculosis is in progress. Proposed topics from the morning discussion were reviewed. Once the retrospective review of NSAIDs is completed, the Board plans to evaluate whether that topic should be considered for a bulletin.

**g. Prospective DUR: Fee-for-Service**

- Review of DUR Alerts for New GCNs in 4Q2018 (October – December 2018): At each Board meeting, a list of new GCN additions with prospective DUR alerts turned on other than DD, ER, and PG are provided to the Board for review. At this meeting, the Board reviewed the alert profiles of the following GCNs:
  - GCNs #078155 – #078160: ARIPIPRAZOLE – Drug-Disease (MC), Therapeutic Duplication (TD), Late Refill (LR), Additive Toxicity (AT), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)

- GCN #078957: CHLORPHENIRAMINE/PE/CODEINE – Additive Toxicity (AT), Drug-Age (PA)
- GCNs #078661 – #078863: CLOBAZAM – Additive Toxicity (AT)
- GCNs #078712 and #079289: DIAZEPAM – Additive Toxicity (AT), High Dose (HD), Low Dose (LD)
- GCNs #078815 and #078816: ESTRADIOL – Drug-Disease (MC)
- GCN #079213: ESTRADIOL HEMIHYDRATE – Drug-Disease (MC)
- GCN #078757: FENTANYL CITRATE/PF – Drug Allergy (DA), Drug-Disease (MC), Therapeutic Duplication (TD), Additive Toxicity (AT), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCNs #078729 – #078731: HYDROMORPHONE – Additive Toxicity (AT)
- GCNs #079369 and #079370: LEVOTHYROXINE SODIUM – Therapeutic Duplication (TD), Late Refill (LR), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCNs #078733 and #078734: LORAZEPAM – Additive Toxicity (AT), High Dose (HD)
- GCNs #078735 – #078737: MEPERIDINE HCL/PF – Additive Toxicity (AT)
- GCNs #079083, #079085, and #079887: TESTOSTERONE ENANTHATE – Drug Allergy (DA), Therapeutic Duplication (TD), Late Refill (LR), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)

There were no questions or objections to these alert profile recommendations. There was no further discussion.

- ii. Therapeutic Duplication (TD) Alert: Update – Ms. Fingado reported that the TD alert for lithium has been turned off for non-300 mg formulations and the ingredient duplication (ID) alert is now on for all formulations of quetiapine, so as to distinguish between true therapeutic duplication with other antipsychotic medications and not have it combined with two formulations of quetiapine.

There were no questions or objections to these alert profile recommendations. There was no further discussion.

- iii. Additive Toxicity (AT) Alert: Gabapentinoids – Ms. Fingado reported that gabapentinoids are under consideration for addition to the list of drugs for the AT alert based on side effect profile, literature review, and analysis of pharmacy claims data. Ms. Fingado stated that many states are limiting claims to FDA-approved diagnoses or have taken legislative action to classify gabapentin as a scheduled drug, in order to allow gabapentin claims to be reported as part of the prescription drug monitoring program. Ms. Fingado asked if the Board would have interest in a retrospective DUR review of the class of gabapentinoids, including ICD-10 data and concomitant medications.

Dr. Zuniga agreed this should be reviewed and suggested looking at emergency department visits as well. Dr. Albertson reported that these drugs are being abused in the prison population. Dr. Leung suggested also looking at beneficiaries taking both gabapentin and pregabalin as a recent study found combination therapy might be of benefit to certain patients.

Dr. Stafford confirmed that the review would include both pregabalin and gabapentin. Dr. Stebbins motioned to conduct a retrospective DUR review of gabapentinoids. The motion was seconded. There was no further discussion. The motion was approved.

**AYE:** Albertson, Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Walker, Wong, Zuniga

**NAY:** None

**ABSTAIN:** None

**ABSENT:** None

**ACTION ITEM:** The DUR Board recommendation to conduct a retrospective DUR review of gabapentinoids will be submitted to DHCS.

**h. DUR Educational Outreach to Providers: Fee-for-Service**

- i. Outcomes: Additive Toxicity – Ms. Fingado presented details from the provider letter aimed at educating health care providers about the recent changes to the additive toxicity (AT) alert within the Medi-Cal fee-for-service population. Ms. Fingado reported that the study population included 31 beneficiaries who were continuously eligible in the Medi-Cal fee-for-service program between October 1, 2018, and January 31, 2019. Each beneficiary generated an AT alert with pharmacist override during December 2018 and had at least one paid claim for both an opioid and a benzodiazepine, as well as paid claims for at least two additional CNS depressants between October 1, 2018, and December 31, 2018. A total of 67 prescribers were identified for educational outreach letters, which were mailed on January 18, 2019. Any paid claims for gabapentin during the same time period were also included on patient profiles. Ms. Fingado reminded the Board that the primary outcome is the total number of continuously eligible beneficiaries without active paid claims for both opioids and benzodiazepines after 6 months following the mailing. The secondary outcome is the total number of continuously eligible beneficiaries with a paid claim for naloxone within 6 months following the mailing. These outcomes, as well as the response rate and returned mail rate will be presented at the November 2019 Board meeting.

**i. Pharmacy Update presented by Pauline Chan**

Before Ms. Chan began discussion of the pharmacy update topics, she noted that the proposal describing the DUR Vital Directions Framework was not discussed during the morning session due to time constraints. Dr. Stafford then presented the slides from the morning session and described the components of the proposed framework, including the vision, core goals, action priorities, and essential infrastructure needs. Dr. Stafford motioned that the Board use the DUR Vital Directions Framework to guide priority area topic clusters. The motion was seconded. There was no further discussion. The motion was approved.

**AYE:** Albertson, Blatt, Chan, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Walker, Wong, Zuniga

**NAY:** None

**ABSTAIN:** None

**ABSENT:** None

**ACTION ITEM:** The DUR Board recommendation to use the DUR Vital Directions Framework to guide priority area topic clusters will be submitted to DHCS.

- i. Naloxone – Ms. Chan then provided an overview of the [Naloxone Distribution Project \(NDP\)](#), a project funded by SAMHSA and administered by DHCS to combat opioid overdose-related deaths throughout California. The NDP aims to address the opioid crisis by reducing opioid overdose deaths through the provision of free naloxone, in its nasal spray formulation. Ms. Chan stated that the NDP application and additional materials can be found at the link provided. Ms. Chan also provided a link to [Naloxone Access Options in California](#), an informational document for different stakeholders who may be seeking access to the use of naloxone.
- ii. CDC Opioid Guidelines – Ms. Chan reported that the CDC is now offering an online training series for health care providers: [Applying CDC's Guidelines for Prescribing Opioids](#). Ms. Chan stated this interactive training series offers training modules and continuing education, and noted that a mobile application is available. Ms. Chan added that DHCS is considering ways to adopt the CDC's guidelines.
- iii. 2019 Child Core Set – Ms. Chan reported that the [2019 Child Core Set](#) had no new measures added or retired from the 2018 Child Core Set, and that further details could be found at the provided link, [Children's Health Care Quality Measures](#).
- iv. 2019 Adult Core Set – Ms. Chan reported that the [2019 Adult Core Set](#) also had no new measures added or retired from the 2018 Adult Core Set, and that further details could be found at the provided link, [Adult Health Care Quality Measures](#).
- v. CMS All State DUR Meeting – Ms. Chan briefly summarized the webinar with CMS, which was held on January 22, 2019. She stated that slides from this meeting can be

	<p>found in the packet and she encouraged everyone to review the information provided, including information about the annual report and the <a href="#">SUPPORT Act</a>. Ms. Chan confirmed CMS would be providing additional guidance on the SUPPORT Act in the upcoming months.</p> <p>vi. CMS DUR Annual Report 2018 Timeline – Ms. Chan encouraged everyone to review the annual report timeline in the slide deck. Ms. Chan reiterated that the release of submission links will be on March 1, 2019, and the final report, which will include the report from FFS and all MCOs, must be submitted to CMS by July 1, 2019.</p> <p>j. Recap of today's action items – Dr. Orozco and Ms. Fingado read the Board action items from the afternoon session. There were no comments.</p> <p>k. Looking ahead: Call for future meeting agenda – Ms. Chan stated that she welcomes recommendations from the Board for speakers and that the May meeting will include a presentation by Heidi Holtz, MD, MEd from Anthem Blue Cross Partnership Plan. Ms. Chan thanked Dr. Zuniga for the recommendation.</p>
<b>7) PUBLIC COMMENTS</b>	<ul style="list-style-type: none"> <li>There were no public comments. Dr. Stafford reminded the Board to complete the feedback form.</li> </ul>
<b>8) CONSENT AGENDA</b>	<ul style="list-style-type: none"> <li>The next Board meeting will be held from 9:30 a.m. to 3:00 p.m. on May 21, 2019, in the DHCS 1<sup>st</sup> Floor Conference Room located at 1700 K Street, Sacramento, CA 95814.</li> </ul>
<b>9) ADJOURNMENT</b>	<ul style="list-style-type: none"> <li>The meeting was adjourned at 3:00 p.m.</li> </ul>

Action Items	Ownership
Incorporate Dr. Wong's edits into the November minutes and post to the DUR website.	Amanda
The DUR Board recommendation to complete an additional review of the TAR drug data to determine the percentage of TARs for each drug that are due to the statutory prescription limit and the top three reasons for denials among antipsychotic medications will be submitted to DHCS.	Paul/Ivana
The DUR Board recommendation to review best practices for prior authorization process improvement and strategies to prevent filling prescriptions that are already cancelled will be submitted to DHCS.	Amanda/Pauline
The DUR Board recommendation to review the use and prescribing of opioids in the emergency department and surgical setting and a review of naloxone prescribing after the implementation of the new legislative requirements in California will be submitted to DHCS.	Amanda
The DUR Board recommendation to review diabetes management, hypertension management, asthma management, and immunizations within populations with chronic disease, including a review of best practices among managed health care plans will be submitted to DHCS.	Amanda/Pauline
The DUR Board recommendation to approve the FFY 2018 DUR Annual Report to CMS for the Medi-Cal Fee-for-Service program will be submitted to DHCS.	Amanda/Pauline
The DUR Board recommendation to present generic utilization and expenditure data exclusive of carved out drugs for all FFS beneficiaries and MCPs (by plan) and also for all carved out drugs.	Amanda
The DUR Board recommendation to archive the varenicline alert will be submitted to DHCS.	Amanda
The DUR Board recommendation to conduct a retrospective DUR review of gabapentinoids will be submitted to DHCS.	Amanda
The DUR Board recommendation to use the DUR Vital Directions Framework to guide priority area topic clusters will be submitted to DHCS.	Pauline

## Board Action Items from February 26, 2019

- Complete an additional review of the TAR drug data to determine the percentage of TARs for each drug that are due to the statutory prescription limit and the top three reasons for denials among antipsychotic medications.
  - Data from Q1 2019 will be presented today.
- Review best practices for prior authorization process improvement and strategies to prevent filling prescriptions that are already cancelled.
  - Best practices collated from Annual Reports will be presented today.
- Review the use and prescribing of opioids in the emergency department and surgical setting and a review of naloxone prescribing after the implementation of the new legislative requirements in California.
  - Approved; will be presented in November.
- Review diabetes management, hypertension management, asthma management, and immunizations within populations with chronic disease, including a review of best practices among managed health care plans.
  - Best practices collated from Annual Reports will be presented today.



## Board Action Items from February 26, 2019 (cont.)

- Approve the FFY2018 DUR Annual Report to CMS for the Medi-Cal Fee-for-Service program.
  - Submitted; need Board Chair signature on cover letter.
- Present generic utilization and expenditure data exclusive of carved-out drugs for all FFS beneficiaries and MCPs (by plan) and also for all carved-out drugs.
  - FFS exclusive of carved-out drugs (FFY 2018) generic utilization 82.5% (vs. 74.1%) and generic expenditure 15.7% (vs. 7.3%)
  - MCP (FFY 2018) generic utilization range 83.5% - 96.2%
  - Carved-out (FFY 2018) generic utilization 56.2% and generic expenditure 3.1%
- Archive the varenicline alert.
  - Completed.
- Conduct a retrospective DUR review of gabapentinoids.
  - Approved; will be presented today.
- Use the DUR Vital Directions Framework to guide priority area topic clusters.
  - Approved.





**GLOBAL MEDI-CAL DRUG USE REVIEW BOARD  
February 26, 2019 BOARD MEETING MCP ACTIONS**

MCP: \_\_\_\_\_

Name of DUR representative: \_\_\_\_\_ Attended meeting? Yes \_\_\_\_ No \_\_\_\_

**Summary of Required Actions**

- I. Educational Bulletins:** MCP to have a process for distribution of provider education programs and materials developed by Global DUR Board to their providers via established mechanisms.

<b>Required dissemination of DUR educational bulletins and alerts</b>		
<b>Description</b>	<b>Mechanism of dissemination</b>	<b>Date of Dissemination</b>
January 2019 Alert: <a href="#">New Naloxone Regulations Effective on January 1, 2019</a>		

**Summary of Global Medi-Cal DUR Board Activities  
(not required to document on the Annual Report to CMS)**

1. MCPs should have a general understanding of the [DHCS Quality Strategy](#), with a focus on [2019 Child and Adult Core Set](#)
2. CMS announced the FFY 2018 DUR MCO Annual Report fillable PDF questionnaire will be released around March 1, 2019. DHCS will download the blank questionnaire and distribute to MCPs.

Action:

- a. FFY 2018 reports are due April 2, 2019.
  - b. Submit questions to DHCS promptly.
  - c. Use the standardized format for naming attachments.
3. Review Board Goals and Priorities:
  - a. Optimizing Drug Prescribing and Dispensing, including specialty drugs
  - b. Optimizing Pain Management and Opioids
  - c. Optimizing Chronic Disease Management, including prevention

Action:

- a. Review board goals and priority areas at MCPs P&T Committee.
  - b. Submit innovative practices on priority areas MCPs has worked on and share lessons learned, with focus on asthma, diabetes, and hypertension.
4. Review Fee-For-Service Treatment Authorization Report.

Action:

- a. Consider collecting similar data (top 30 prior authorization drugs).
  - b. Evaluate prior authorization program effectiveness (drugs no longer require PA, identify high PA acceptance/denials).
5. Best practices presentation: Inland Empire Health Plan Pay For Performance Program

Action:

- a. Collect data on alert overrides and conduct a review.
  - b. Evaluate opportunities to reduce excessive overrides.

**Reminders**

- MCPs are required to ensure representation and participation at Global Medi-Cal DUR Board meetings, either in-person or via webinar. Refer to the Global Medi-Cal DUR Board bylaws for the attendance requirements for Global Medi-Cal DUR Board members.
- MCPs are required to have a process for distribution of provider education programs and materials developed by Global Medi-Cal DUR Board to their providers.



## FFY 2018 DUR Annual Report: Medi-Cal Managed Care Plan Summary

Pauline Chan, R.Ph., MBA  
May 21, 2019

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### Average Monthly Medi-Cal Enrollment

- 26 plans completed annual report
- Range: 660 – 1,824,406 beneficiaries
- Mean: 393,386 beneficiaries



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### Prospective DUR Criteria

- 10 plans have their own DUR Boards
- 13 plans receive reports with pharmacy override activity at least annually
- 5 plans follow up with providers who routinely override alerts



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Early Refill: Threshold for Edits		
Non-controlled drugs		
	Plans (n)	
70%	4	
75%	8	
80%	8	
85%	3	
90%	3	
Mean: 79%		
Schedule II drugs		
	Plans (n)	
70%	2	
75%	4	
80%	6	
85%	1	
90%	13	
Mean: 84%		
Schedule III-V drugs		
	Plans (n)	
70%	3	
75%	4	
80%	5	
85%	2	
90%	12	
Mean 83%		

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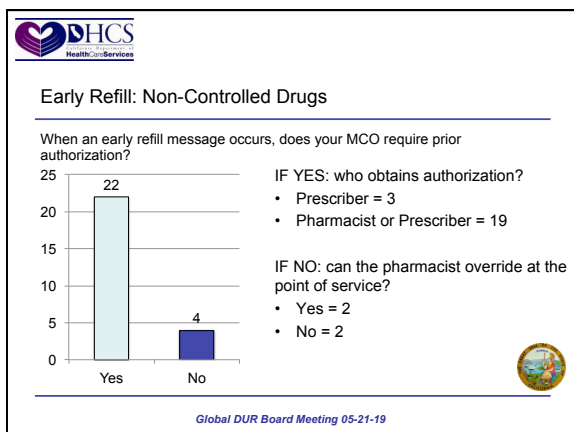
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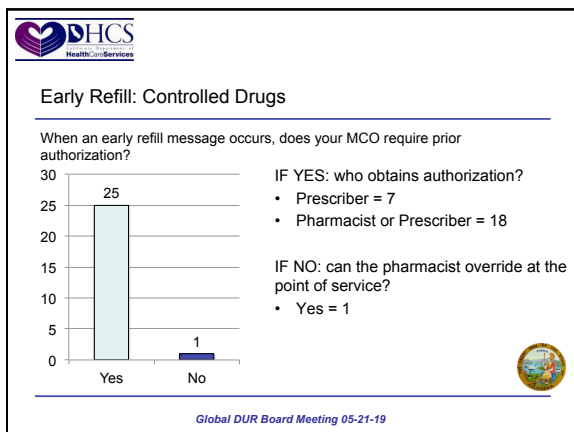
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 **DHCS**  
Health Services

**Early Refill**

- Pharmacist override of ER alert
  - 11 plans allow for lost/stolen Rx
  - 10 plans allow for vacation
  - 18 plans allow for other reasons
- 6 plans have accumulation edit
- 10 plans have policy prohibiting auto-refill
- 4 plans have refill synchronization policy 

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 **DHCS**  
Health Services

**Top 10 Prior Authorization Requests by Drug Name**

- 75 drugs in the Top 10
- Most frequent drugs recorded:
 

• OXYCODONE HCL (n = 21)	• TEST STRIPS (n = 10)
• PREGABALIN (n = 20)	• NUTRITIONAL SUPPLEMENT (n = 9)
• GLECAPREVIR/PIBRENTASVIR (n = 14)	• TRETINOIN (n = 8)
• AMPHETAMINE/ DEXTROAMPHETAMINE (n = 11)	• ADALIMUMAB (n = 7)
• HYDROCODONE/ ACETAMINOPHEN (n = 10)	• DICLOFENAC SODIUM (n = 7)
• LIDOCAINE (n = 10)	• LISDEXAMFETAMINE DIMESYLATE (n = 7)



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 **DHCS**  
Health Services

**Top 10 Prior Authorization Requests by Drug Class**

- 92 drug classes in the Top 10
- Most frequent drug classes recorded:
 

• ANTICONVULSANTS (n = 20)	• GLP-1 RECEPTOR AGONIST (n = 8)
• INSULIN (n = 14)	• OPIOID AGONISTS (n = 6)
• OPIOID ANALGESICS (n = 14)	• OPIOID COMBINATIONS (n = 6)
• AMPHETAMINES (n = 12)	• PROTON PUMP INHIBITORS (n = 6)
• DIETARY SUPPLEMENTS (n = 10)	
• HEPATITIS C ANTIVIRALS (n = 12)	



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 **DHCS**  
Health Services

**Top 5 Claim Reason Denials**

- 21 denial reasons in the Top 5
- Most frequent reasons recorded:
  - PRODUCT/SERVICE NOT COVERED OR ON FORMULARY (n = 26)
  - REFILL TOO SOON (n = 26)
  - DAYS SUPPLY EXCEEDS PLAN MAXIMUM (n = 13)
  - PRIOR AUTHORIZATION REQUIRED (n = 11)
  - QUANTITY DISPENSED EXCEEDS MAXIMUM ALLOWED (n = 9)
  - PLAN LIMITATIONS EXCEEDED (n = 8)



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 **DHCS**  
Health Services

**Top 10 Drug Names by Amount Paid**

- 68 drugs in the Top 10
- Most frequent drugs recorded:
  - INSULIN GLARGINE (n = 26)
  - GLECAPREVIR/PIBIRENTASVIR (n = 22)
  - ADALIMUMAB (n = 21)
  - ALBUTEROL SULFATE (n = 21)
  - ETANERCEPT (n = 17)
  - INSULIN LISPRO (n = 16)
  - SITAGLIPTIN PHOSPHATE (n = 13)
  - TEST STRIPS (n = 12)
  - SOFOSBUVIR/VELPATASVIR (n = 9)
  - BECLOMETASONE DIPROPIONATE (n = 8)



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 **DHCS**  
Health Services

**Top 10 Drug Names by Claim Count**

- 37 drugs in the Top 10
- Most frequent drugs recorded:
  - IBUPROFEN (n = 24)
  - METFORMIN HCL (n = 22)
  - ALBUTEROL SULFATE (n = 21)
  - ATORVASTATIN CALCIUM (n = 20)
  - GABAPENTIN (n = 19)
  - LISINAPRIL (n = 18)
  - OMEPRAZOLE (n = 16)
  - AMLODIPINE BESYLATE (n = 15)
  - AMOXICILLIN (n = 15)
  - HYDROCODONE/ACETAMINOPHEN (n = 15)
  - LORATADINE (n = 14)
  - ASPIRIN (n = 11)
  - CHOLECALCIFEROL (n = 11)



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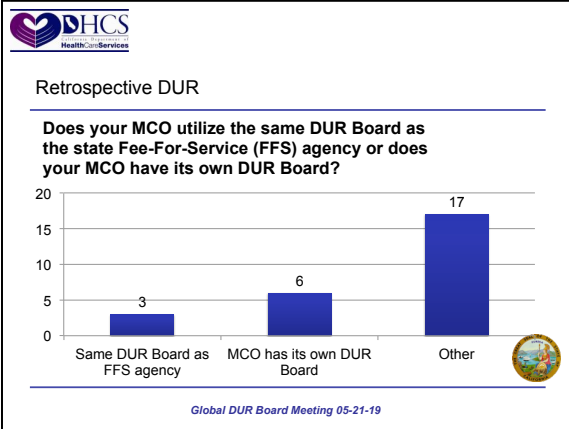
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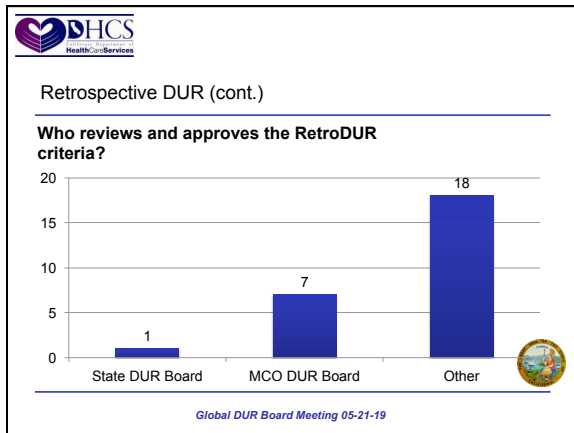
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 **DHCS**  
Health Services

Physician Administered Drugs (PADs)

- 2 plans incorporate PADs into ProDUR
  - 2 planning to include in future
- 4 plans incorporate PADs into RetroDUR
  - 4 planning to include in future



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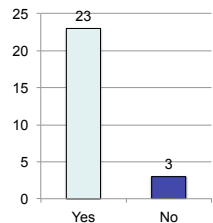
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 **DHCS**  
Health Services


Generic Policy

Does your MCO have a more restrictive brand drug policy?



Response	Count
Yes	23
No	3

- Prior authorization is required = 22
- Require that a MedWatch Form be submitted = 10
- Require the medical reason(s) for override accompany the prescription = 9
- Prescriber must indicate "Brand Medically Necessary" on the prescription = 5
- Try and fail with at least 1 generic = 2
- Try and fail with at least 2 generics = 1



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 **DHCS**  
Health Services

Generic Utilization Percentage

- Mean 88.1%
- Range: 81.5% - 96.2%
- 4 plans above 90%



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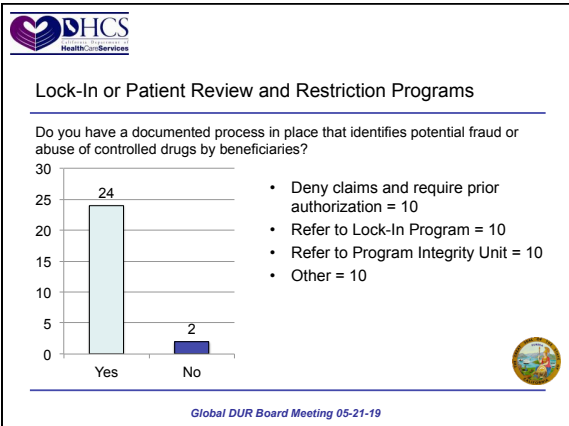
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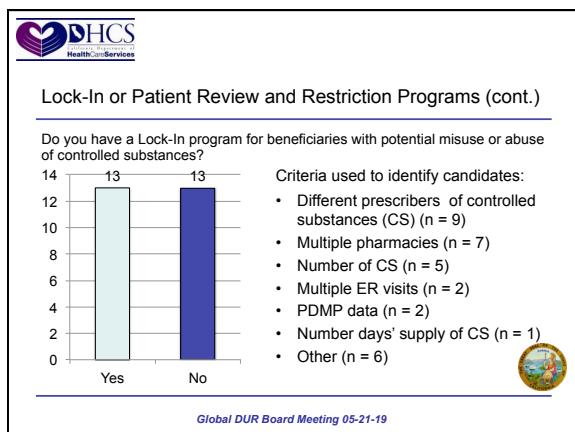
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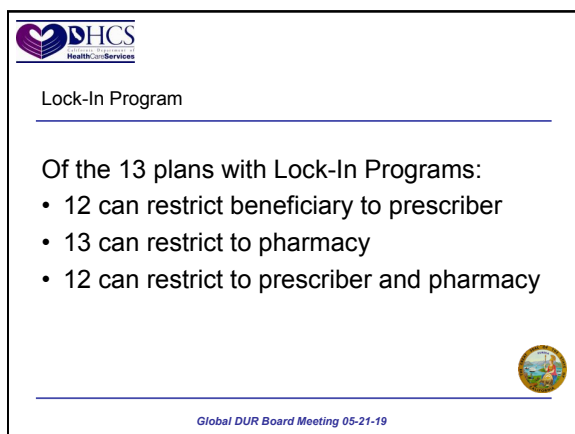
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#### Lock-In Program (cont.)

Of the 13 plans with Lock-In Programs:

- 9 have a 12 month Lock-In period
- 1 has a 24 month Lock-In period
- 3 have variable policies

Percentage of population in Lock-In annually ranged from 0 to 1%



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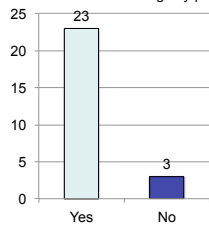
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#### Process to Identify Fraud or Abuse: Prescribers

Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?



- Deny claims written by prescriber = 6
- Refer to Program Integrity Unit = 17
- Refer to the appropriate Medical Board = 7
- Other = 11



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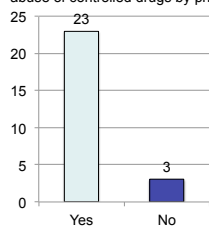
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#### Process to Identify Fraud or Abuse: Pharmacy Providers

Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by pharmacy providers?



- Deny claims written by prescriber = 11
- Refer to Program Integrity Unit = 18
- Refer to Board of Pharmacy = 12
- Other = 17



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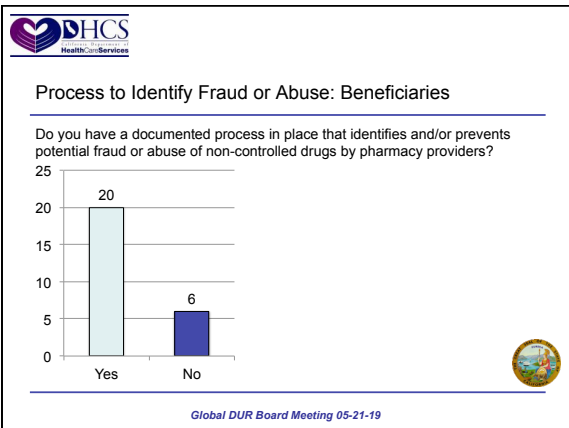
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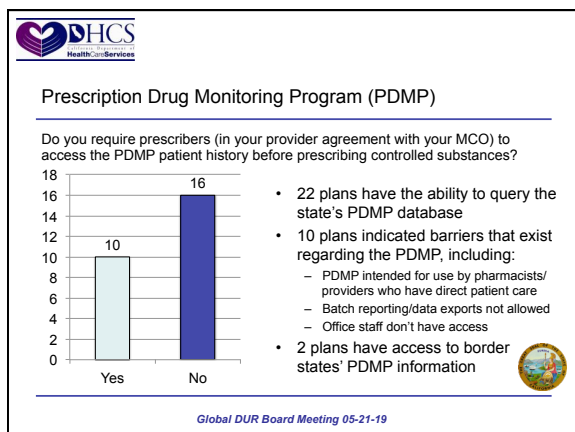
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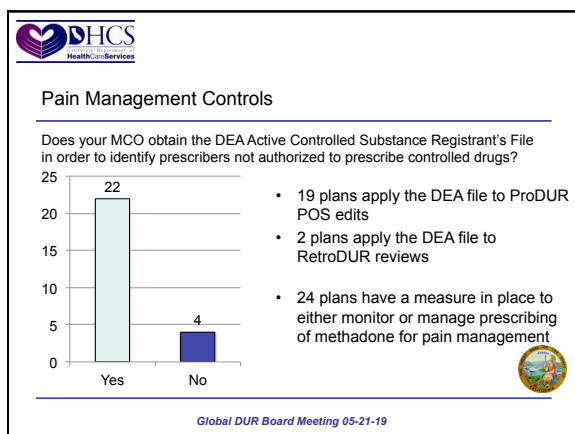
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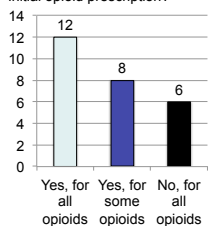
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### Opioids: Initial Prescriptions

Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription?



- 16 plans have more than one quantity limit for the various opioids
- Maximum days for initial opioid prescriptions:
  - 7 days (n = 5)
  - 30 days (n = 13)
  - 31 days (n = 2)
- 12 plans apply initial day limit to all opioid prescriptions

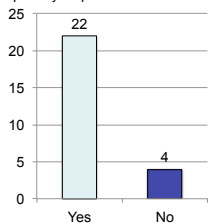


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### Opioids: Subsequent Prescriptions

For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting and long-acting opioids?



- Maximum days for subsequent short-acting opioid prescriptions:
  - 30 days (n = 19)
  - 31 days (n = 2)
  - 90 days (n = 1)
- Maximum days for subsequent long-acting opioid prescriptions:
  - 30 days (n = 17)
  - 31 days (n = 2)
  - 90 days (n = 1)
  - Variable (n = 2)



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### Opioids: Other Measures to Monitor/Manage Prescribing

- Deny claim and require PA (n = 22)
- Step therapy or clinical criteria (n = 16)
- Morphine equivalent daily dose (MEDD) program (n = 14)
- Intervention letters (n = 12)
- Requirement that prescriber has an opioid treatment plan for patients (n = 10)
- Requirement that patient has a pain management contract or Patient-Provider agreement (n = 5)
- Pharmacist override (n = 5)
- Require documentation of urine drug screening results (n = 3)



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#### Opioids: Other Prescribing Controls Described by Plans

- Concurrent prescribing of naloxone and long acting opioid
- Prescriber attestations
- Retrospective DUR reviews
- Morphine equivalent daily dose limits
- Quarterly report cards for top opioid prescribers
- Interdisciplinary care teams
- Intensive case management for beneficiaries
- Code 1 restrictions
- Prescriber outreach



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#### Opioids: Other Interventions

- 12 plans have edits to monitor opioids and benzodiazepines used concurrently
- 8 plans perform RetroDUR and/or provider education in regard to beneficiaries with history of opioid use disorder/opioid poisoning diagnosis
  - Annually (n = 3)
  - Quarterly (n = 2)
  - Monthly (n = 1)
  - Variable, as needed (n = 2)



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#### Opioids: Prescribing Guidelines

- 22 plans refer prescribers to CDC's Guideline for Prescribing Opioids for Chronic Pain
- 11 plans refer to other guidelines, including:
  - Medical Board of California Guidelines for Prescribing Controlled Substances for Pain
  - MCO developed guidelines
  - Practice/Specialty/Society developed guidelines
  - CMS Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction



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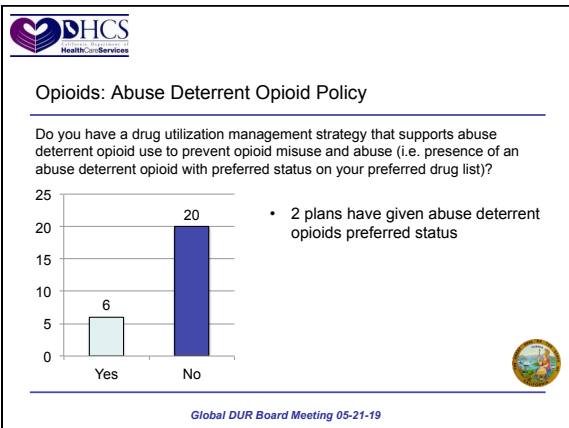
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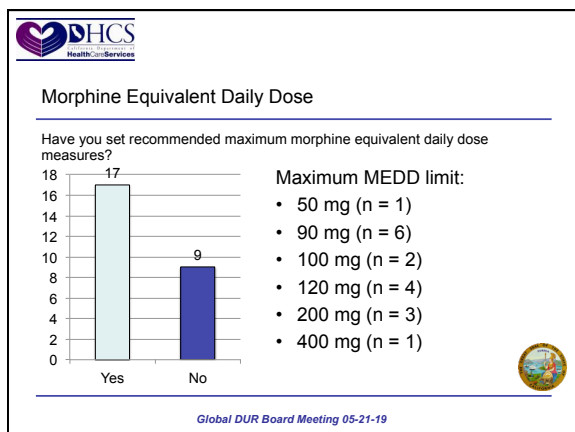
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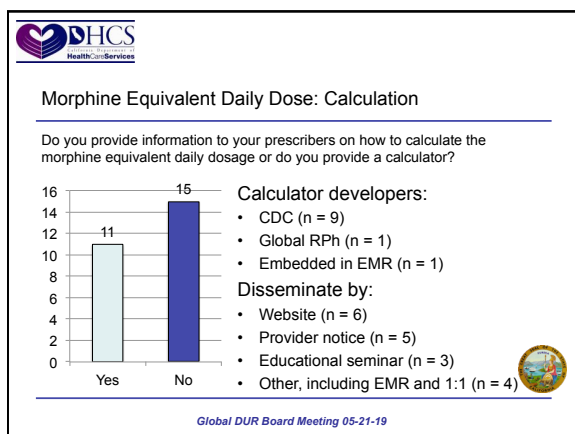
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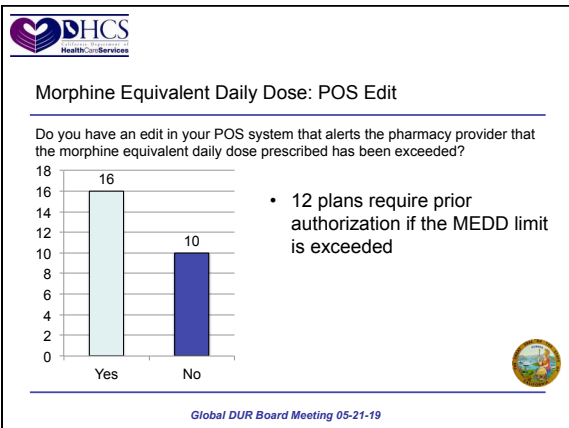
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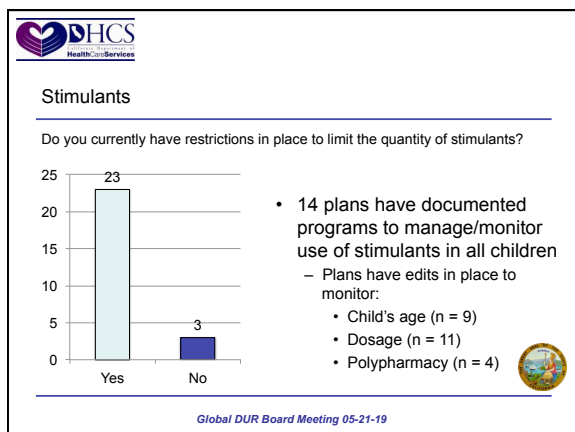
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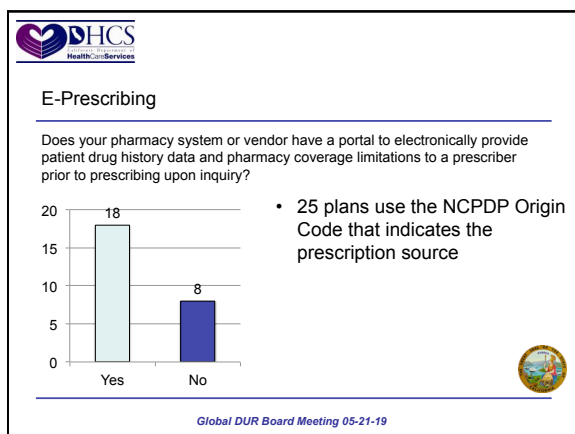
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## Acknowledgement

Special thanks to the following for their contribution to the report summary:

- Amanda Fingado, MPH
- David Do, Pharm.D.
- Jose Villalobos, MPA



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## Questions?



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## FFY 2018 Medi-Cal Managed Care DUR Annual Report Innovative Practices Summary

Pauline Chan, R.Ph., MBA  
February 26, 2019



## Innovative Practices

- 26 Medi-Cal Managed Care Health Plans
- 72 Innovative Practices with focus on:
  - Improve the DUR program
    - Substance Use Disorder, opioids Use, hepatitis C
  - Improve appropriate drug prescribing and use
    - Chronic condition management, complex care, MTM, academic detailing, automated prior authorization, alternate to PA, reduce overrides, continuing education, clinical guidelines
  - Increase access of care
    - Naloxone access



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## Innovative Practices - 2

- Improve coordination of care
  - Transition of care, discharge planning
- Alignment of benefits
  - Medical benefits and Pharmacy benefits
- Cross agency collaboration
  - County-wide Coalition, referrals to CCS
- Cost effectiveness
  - Pharmaceutical pipeline monitoring, Biosimilar, Technology drivers, cost savings initiatives (quality limits), MAC management, trending high utilization
- Value based purchasing
  - Pay for performance



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3



## Innovative Practices -3

Plan	Innovative Practices
1	Biosimilar Products
	MEDD Limits
	Stimulant Guidelines
	Hepatitis C Preferred Drugs & Case Management
	Lock-In Program
	Referrals to California Children's Services
2	Pharmaceutical Pipeline Monitoring
	Program Integrity – Fraud, Waste and Abuse (FWA)
	MTM
3	Asthma Adherence New Starts
	Diabetes Polypharmacy

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## Innovative Practices -4

Plan	Innovative Practices
3	Retrospective Safety Review
4	Three-Prong Approach to Substance Use Disorder
	Step-Wide Approach to Address Opioid Safe Use
	Hepatitis C Preferred Drugs & Case Management
5	Cost Savings Initiatives
	MedResults Physician Directed Program Flow
6	Reducing Inappropriate Proton Pump Inhibitors Use
	Expanding Naloxone Access via Partnership with CVS
	MTM
7	Opioids Use Initiative

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## Innovative Practices -5

Plan	Innovative Practices
8	Opioids Cumulative Dosing
	Hepatitis C Preferred Drugs
	AirDUO Migration Campaign
9	Academic Detailing: Opioids, Diabetes, Asthma
	Opioid Guidelines
	Policy Alignment: Medical Benefits & Pharmacy Benefits
10	Asthma
11	Program Integrity: FWA and Built-In Edits
	Pharmaceutical Pipeline Monitoring
	Maximum Allowable Cost (MAC) Management
	MedResults- Gaps in Asthma Report

6

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## Innovative Practices -6

Plan	Innovative Practices
12	Opioids
	Smoking Cessation
	Hepatitis C
13	Trending High Utilization
	High Volume Pharmacy Audit
14	Opioids
15	County-wide Opioids Safety Coalition
	Opioids Quantity Limits
16	Pay For Performance (P4P)
	Reducing "Routine" Overrides

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## Innovative Practices -7

Plan	Innovative Practices
17	Emerging Therapeutic Strategy Program: Specialty Pharmaceuticals, Biotechnology, Pharmacogenomics, Other Technology Drivers
	Collaborative Formulary Development as Alternate to PA
18	Transition of Care
	Complex Care Rounds
	Inpatient Rounds for Discharge Preparation
	Synagis
	Diabetes Clinics (Statins use)
	Insulin
	Hydrocortisone Quantity Limits

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## Innovative Practices -8

Plan	Innovative Practices
19	Triple Threat: Opioids/Benzos/Muscle Relaxants
	Academic Detailing: Opioids
	Concurrent DUR (CDUR) benzos/opioids
	CDUR Pediatric Use of Codeine & Tramadol
	CDUR MMED Edits
20	Pain Safety Initiative Task Force
21	Asthma Medication Ratio (AMR): Patient Engagement
22	Pharmaceutical Pipeline Monitoring
	Maximum Allowable Cost (MAC) Management
	Generic First Program
	Program Integrity with Onsite Desktop Audits

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## Innovative Practices -9

Plan	Innovative Practices
19	Triple Threat: Opioids/Benzos/Muscle Relaxants
	Academic Detailing: Opioids
	Concurrent DUR (CDUR) benzos/opioids
	CDUR Pediatric Use of Codeine & Tramadol
	CDUR MMED Edits
20	Pain Safety Initiative Task Force
21	Asthma Medication Ratio (AMR): Patient Engagement
22	Pharmaceutical Pipeline Monitoring
	Maximum Allowable Cost (MAC) Management
	Generic First Program
	Program Integrity with Onsite Desktop Audits

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## Innovative Practices -9

Plan	Innovative Practices
23	Hepatitis C Treatment Management
	DUR Trend Analytics and Management
	Streamline Prior Authorization: Semi-Automation
24	Online Member Portal of Medi-Cal Members
	Valley Medical Center Homeless Healthcare Program
	Therapeutic Alternative Notification
25	Opioids
	Acetaminophen Toxicity
26	Simplify the Way Your Prescribe Medicine
	Reduce Prior Authorization by PreCheck MyScript

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## Proposed Next Steps

- Invite health plans to present at DUR board future meetings
  - Live presentation with Q&A
  - Poster presentation (lunch break)
- Schedule webinar presentations
  - By topics
  - Panel Discussion
  - Case Studies
- Consider other shared learning opportunities



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## Ask

- How do we evaluate innovative practices?
  - Best practice, sustainability
- Which practices are DUR's priority?
  - High impact change
- How is improvement measured?
  - Quality strategy alignment
- Where do we go from here?



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## Important Reminders

- Election for the Global DUR Board Vice Chair will be held at the September 17, 2019 meeting
  - All candidates must submit a brief (no more than one page) statement to DHCS by August 1, 2019.
  - Email statements to [Pauline.Chan@dhcs.ca.gov](mailto:Pauline.Chan@dhcs.ca.gov).
- Proposed Board meeting dates for 2020:
  - Tuesday, March 3, 2020
  - Tuesday, May 19, 2020
  - Tuesday, September 15, 2020
  - Tuesday, November 17, 2020
  - Email known conflicts to [Pauline.Chan@dhcs.ca.gov](mailto:Pauline.Chan@dhcs.ca.gov).





## Retrospective DUR Updates: Q1 2019

Amanda R. Fingado, MPH  
Senior Epidemiologist/Statistician  
Department of Clinical Pharmacy

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## Retrospective DUR Updates – Q1 2019

Topic for Discussion

- Global Annual Report (January – December 2018)
- FFS Quarterly Report: 1Q2019 (January – March 2019)
- Biennial Report 2018: Part II
- Review: Gabapentinoids

2 Retrospective DUR Update UCSF

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## Global Annual Report: 2018

- Global quarterly report for 2Q2018 presented at February Board meeting
  - Data were pulled again 3 months later: 99.2% complete
  - Propose presenting quarterly data one quarter behind FFS
- Global annual report reflects this (data through December 2018)
- Per Board request, edits were made to Tables 4 and 6
  - Denominator of stratified columns is total paid claims and total utilizing beneficiaries within each program as shown in Table 1

3 Retrospective DUR Update UCSF

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## Global Annual Report: 2018 – Summary

- Among all Medi-Cal beneficiaries with a paid pharmacy claim
  - Approximately 10% were FFS enrollees
  - Approximately 88% were MCP enrollees
  - Approximately 2% had enrollments in both during 2018
- MCP enrollees had a greater average number of paid pharmacy claims per eligible beneficiary (4.53 vs. 0.98)
- MCP enrollees have a greater average number of paid pharmacy claims per utilizing beneficiary (5.16 vs. 10.19),

4 Retrospective DUR Update




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## Global Annual Report: 2018 – Stratified

- MCP enrollees had a greater % total paid claims for:
  - OMEPRAZOLE (1.6% vs. 0.9%)
  - FLUTICASONE PROPIONATE (1.6% vs. 0.6%)
- FFS enrollees had a greater % of total paid claims for:
  - FERROUS SULFATE (2.2% vs. 0.9%)
  - DOCUSATE SODIUM (2.3% vs. 0.9%)

5 Retrospective DUR Update




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Board recommendations?

6 Retrospective DUR Update




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## FFS Quarterly Report: 1Q2019

- Stratified tables represent 95.4% of paid claims
- Eligible beneficiaries decreased from prior quarter (decreased by 2%) and prior-year quarter (decreased by 3%)
- Table 6.3: Top 20 Fee-for-Service Drugs by Total Utilizing Beneficiaries for the Medi-Cal MCP Population Only
  - Naloxone posted a 249% increase in total paid claims from 2018 Q4
  - California legislation effective January 1, 2019, which requires prescribers to offer a prescription for naloxone for patients meeting certain requirements.

7 Retrospective DUR Update

UCSF

## Board recommendations?

8 Retrospective DUR Update


UCSF

## Biennial Report 2018: Part II

- DUR educational articles are reviewed again at least 2 years after publication to evaluate any change over time
- The 2018 biennial report provides detailed evaluations of 16 DUR educational articles published between October 2014 and September 2016
- Being presented in 2 parts (eight articles each)
  - Part I was presented at the February 2019 meeting
  - Part II being presented today

9 Retrospective DUR Update

UCSF



Board recommendations?

10 Retrospective OAR Update UCSF

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### Gabapentinoids - Background

- Gabapentinoids (gabapentin and pregabalin) are frequently prescribed with opioids for their opioid-sparing and adjuvant analgesic effects.
- Recent reports suggest concomitant use of gabapentinoids and opioids might be an indicator of high-risk opioid misuse and could increase the risk of serious adverse events.
- A 2018 [CDC report](#) of overdose deaths in 11 states found gabapentin detected in 21.6% of prescription opioid-only deaths.
- Pregabalin is a Schedule V controlled substance, however gabapentin is not scheduled under the Controlled Substances Act of 1970.

11 Retrospective OAR Update UCSF

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### Gabapentinoids – Background (cont.)

- Gabapentin is indicated for:
  - Postherpetic neuralgia in adults and adjunctive therapy in the treatment of partial onset seizures, with and without secondary generalization, in adults and pediatric patients 3 years and older with epilepsy
- Pregabalin is indicated for:
  - Neuropathic pain associated with diabetic peripheral neuropathy, postherpetic neuralgia, adjunctive therapy for adult patients with partial onset seizures, fibromyalgia, neuropathic pain associated with spinal cord injury

12 Retrospective OAR Update UCSF

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## Gabapentinoids – State Actions

- Many US states have implemented regulatory approaches to mitigate diversion and abuse of gabapentin.
- During FFY 2018, more than half of state DUR programs completed educational interventions focused on gabapentinoids.
- In the Medi-Cal fee-for-service program, pregabalin is available only with an approved *Treatment Authorization Request* and gabapentin is on the Medi-Cal List of Contract Drugs without any additional restrictions.

13 Retrospective DUR Update




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## Gabapentinoids - Objective

- To evaluate utilization of gabapentinoids in the Medi-Cal population, in order to identify potential drug problems and/or areas where additional review is warranted

14 Retrospective DUR Update




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## Gabapentinoids - Methods

- All paid pharmacy claims for gabapentinoids were reviewed for calendar years 2010 – 2018
  - Stratified by FFS/MCP
- For calendar year 2018, an additional evaluation was conducted for all continuously-eligible FFS enrollees, including:
  - Top concomitant medications by utilizing beneficiary
  - Top primary/secondary diagnosis codes by utilizing beneficiary
  - % of utilizing beneficiaries with FDA-approved indication

15 Retrospective DUR Update




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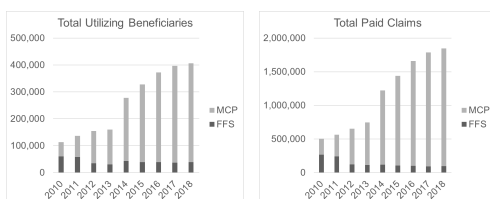
## Gabapentinoids – Results

- A total of 393,514 Medi-Cal enrollees had a paid claim for a gabapentinoid during calendar year 2018
  - 367,367 MCP enrollees
  - 38,532 FFS enrollees
    - 4,102 of these were continuously-eligible in the FFS program for all of calendar year 2018

16 Retrospective DUR Update



## Gabapentinoids – Utilization Trends



January 1, 2014 was the start of the Medi-Cal expansion

17 Retrospective DUR Update



## Gabapentinoids – Top Concomitant Meds

- Drug Therapeutic Category (n = 4,102 FFS beneficiaries)

NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	1,978	48.2%
ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (STATINS)	1,474	35.9%
OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS*	1,380	33.6%
INSULINS	1,206	29.4%
OPIOID ANALGESICS*	1,190	29.0%
ANTIHYPERTENSIVES, ACE INHIBITORS	1,075	26.2%
ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	1,074	26.2%
PROTON-PUMP INHIBITORS	972	23.7%
SKELETAL MUSCLE RELAXANTS	960	23.4%
PENICILLIN ANTIBIOTICS	937	22.8%

\*All categories of opioids = 1,815 (44.2%)

18 Retrospective DUR Update



## Gabapentinoids – Top Concomitant Meds

### Drug (n = 4,102 FFS beneficiaries)

IBUPROFEN	1,163	28.4%
METFORMIN HCL	1,074	26.2%
ATORVASTATIN CALCIUM	941	22.9%
HYDROCODONE/ACETAMINOPHEN	931	22.7%
BLOOD SUGAR DIAGNOSTIC	899	21.9%
LISINAPRIL	805	19.6%
BACLOFEN	796	19.4%
ALBUTEROL SULFATE	703	17.1%
LANCETS	660	16.1%
ESOMEPRAZOLE MAGNESIUM	609	14.8%

19 Retrospective DUR Update




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## Gabapentinoids – Top Diagnoses

### Primary/Secondary Included (n = 4,102 FFS beneficiaries)

ESSENTIAL PRIMARY HYPERTENSION	1397	34.1%
TYPE 2 DM WITHOUT COMPLICATIONS	958	23.4%
CHEST PAIN UNSPECIFIED	643	15.7%
UNSPECIFIED ABDOMINAL PAIN	580	14.1%
LOW BACK PAIN	569	13.9%
UTI SITE NOT SPECIFIED	547	13.3%
SHORTNESS OF BREATH	488	11.9%
COUGH	481	11.7%
HEADACHE	462	11.3%
OTHER CHRONIC PAIN	418	10.2%

20 Retrospective DUR Update




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## Gabapentinoids – FDA Approved

- Broad definition of FDA-approved
- Included all neuralgia, seizures/epilepsy, peripheral neuropathy, fibromyalgia, neuropathic pain
  - Five years worth of diagnosis codes (2014-2018)
- Only 12% of beneficiaries (n = 505) had an FDA-approved diagnosis within those five years
- Off-label use has limited evidence of efficacy
- Potential benefits are uncertain for most off-label uses

21 Retrospective DUR Update




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## Gabapentinoids – Next Steps

### Recommendations:

- DUR educational bulletin focused on gabapentinoids, including use in Medi-Cal population, including the following:
  - Potential for adverse events in high-risk populations
  - Potential for abuse and/or misuse
- DUR educational outreach focused on top prescribers of gabapentinoids

22 Retrospective DUR Update – 2019C2 (01/18 – 6/30/19)




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## Board recommendations?

23 Retrospective DUR Update




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## Future Topics: Retrospective Reviews

- Antihyperglycemic medications (scheduled for September)
- NSAIDs (scheduled for September)
- Annual review of drugs added to the Medi-Cal List of Contract Drugs (ongoing, presented each November)
- HCV medications (ongoing, presented each November)
- Pharmacist furnishing of hormonal contraceptives
- Assessment of opioid use and mortality (stratified by gender)
- Antipsychotic polypharmacy in adults

24 Retrospective DUR Update




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## Future Topics: Adult Core Set Measures

- 2019 Adult Core Set Measures:
  - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)
  - Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
  - Concurrent Use of Opioids and Benzodiazepines (COB-AD)
  - Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)

25 Retrospective QAPI Update




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## Future Topics: Child Core Set Measures

- 2019 Child Core Set Measures:
  - Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
  - Asthma Medication Ratio: Ages 5–18 (AMR-CH)
  - Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)

26 Retrospective QAPI Update




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Board recommendations?

27 Retrospective QAPI Update




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# ANNUAL SUMMARY GLOBAL MEDI-CAL DRUG USE REVIEW CALENDAR YEAR 2018 (JANUARY – DECEMBER 2018)

## Executive Summary

The Global DUR annual report provides information on retrospective drug utilization for all pharmacy claims processed by Medi-Cal. For this report, the retrospective data cover the calendar year of 2018.

**Table 1** provides a summary of pharmacy utilization during calendar year 2018 for the entire Medi-Cal program, as well as stratified by beneficiaries enrolled in Medi-Cal fee-for-service (FFS) and Medi-Cal managed care plans (MCPs). In 2018, only 19.0% of eligible Medi-Cal FFS enrollees had a paid pharmacy claim, compared with 44.4% of Medi-Cal MCP enrollees. Of note, beneficiaries may have enrollments in both Medi-Cal fee-for-service FFS and MCP during the year and therefore may be counted twice in the stratified data given in **Table 1**. Among all Medi-Cal beneficiaries with a paid pharmacy claim through the Medi-Cal program in 2018, only 12.1% were FFS enrollees and 90.1% were MCP enrollees (numbers add up to more than 100% due to 2.2% of beneficiaries being enrolled in both programs during 2018).

In 2018, FFS enrollees were approximately 25.8% of eligible Medi-Cal beneficiaries, 12.1% of utilizing beneficiaries, and 6.3% of total paid pharmacy claims. For 2018, the MCP enrollees have a higher average number of paid pharmacy claims per eligible beneficiary than the FFS enrollees (4.53 vs. 0.98) and a higher average number of paid pharmacy claims per utilizing beneficiary (5.16 vs. 10.19), which may help explain the higher percentage of paid pharmacy claims by MCP enrollees.

As shown in **Table 2**, total paid pharmacy claims increased among all age groups from the prior year (2017), with the exception of the 0 – 12 year age group, which posted a 2.0% decrease in total paid pharmacy claims and a 2.9% decrease in total utilizing beneficiaries.

In this report, two tables highlight utilization among the top 20 drug therapeutic drug categories (**Table 3**) and top 20 drugs (**Table 5**) among all Medi-Cal beneficiaries, in comparison to the prior year. Two additional tables show the top 20 drug therapeutic drug categories (**Table 4**) and top 20 drugs (**Table 6**) along with the corresponding percentages among the FFS and MCP enrollee populations.

**Table 4** suggests more utilizing beneficiaries in the MCP population had paid claims for VITAMIN D PREPARATIONS, NASAL ANTI-INFLAMMATORY STEROIDS, ANTIHISTAMINES – 2<sup>ND</sup> GENERATION, and PROTON-PUMP INHIBITORS than in the FFS population. Similarly, **Table 6** suggests more utilizing beneficiaries in the MCP population had paid claims for OMEPRAZOLE, FLUTICASONE PROPIONATE, and TRIAMCINOLONE ACETONIDE than in the FFS population, while a higher percentage of the FFS population had paid claims for FERROUS SULFATE than the MCP population.

**Table 1. Summary of Global Medi-Cal Pharmacy Utilization.**

This table shows pharmacy utilization in the Medi-Cal program, including the percent change from the prior year. Beneficiaries with enrollments in both FFS and MCP during the year may be counted twice (represents 2.2% of utilizing beneficiaries).

<b>Table 1: Pharmacy Utilization Measures for the Entire Medi-Cal Population</b>			
<b>Category</b>	<b>Current Year 2018</b>	<b>Prior Year 2017</b>	<b>% Change from Prior Year</b>
Total Eligible Beneficiaries	27,184,228	27,697,785	-1.9%
Total Utilizing Beneficiaries	11,023,467	11,077,732	-0.5%
Total Paid Rx Claims	108,151,420	107,365,850	0.7%
Average Paid Rx Claims per Eligible Beneficiary	3.98	3.88	2.6%
Average Paid Rx Claims per Utilizing Beneficiary	9.76	9.69	1.2%
<b>Fee-for-Service Enrollees</b>			
Total Eligible Beneficiaries	7,010,481	7,719,260	-9.2%
Total Utilizing Beneficiaries	1,328,713	1,411,942	-5.9%
Total Paid Rx Claims	6,851,377	7,230,963	-5.3%
Average Paid Rx Claims per Eligible Beneficiary	0.98	0.94	4.3%
Average Paid Rx Claims per Utilizing Beneficiary	5.16	5.12	0.7%
<b>Managed Care Plan Enrollees</b>			
Total Eligible Beneficiaries	22,361,093	22,659,966	-1.3%
Total Utilizing Beneficiaries	9,937,235	9,922,058	0.2%
Total Paid Rx Claims	101,240,538	99,999,622	1.2%
Average Paid Rx Claims per Eligible Beneficiary	4.53	4.41	2.6%
Average Paid Rx Claims per Utilizing Beneficiary	10.19	10.08	1.1%

**Table 2. Pharmacy Utilization by Age Group in the Medi-Cal Population.**

This table presents pharmacy utilization data in the Medi-Cal program, broken out by age group, including the percent change from the prior year.

<b>Table 2: Pharmacy Utilization by Age Group for the Entire Medi-Cal Population</b>						
<b>Age Group (years)</b>	<b>Current Year 2018 Total Paid Claims</b>	<b>Prior Year 2017 Total Paid Claims</b>	<b>% Change from Prior Year</b>	<b>Current Year 2018 Total Utilizing Beneficiaries</b>	<b>Prior Year 2017 Total Utilizing Beneficiaries</b>	<b>% Change from Prior Year</b>
0 – 12	11,988,230	12,237,144	-2.0%	2,759,500	2,842,280	-2.9%
13 – 18	5,447,187	5,277,797	3.2%	1,080,371	1,071,476	0.8%
19 – 39	22,993,817	22,608,020	1.7%	3,023,164	3,013,309	0.3%
40 – 64	58,036,239	57,957,750	0.1%	3,268,342	3,277,766	-0.3%
65+	9,685,928	9,284,968	4.3%	892,081	872,872	2.2%
Total*	108,151,420	107,365,850	0.7%	11,023,467	11,077,732	-0.5%

\* Unknowns represent less than 1% of total

**Table 3. Top 20 Drug Therapeutic Categories in the Medi-Cal Population.**

This table presents utilization of the top 20 drug therapeutic categories in the Medi-Cal program, by **total utilizing beneficiaries**. The current year is compared to the prior year in order to illustrate changes in utilization for these drugs. The prior year ranking of the drug therapeutic category is listed for reference.

<b>Rank</b>	<b>Last Year Rank</b>	<b>Drug Therapeutic Category Description</b>	<b>Current Year 2018 Total Paid Claims</b>	<b>% Change from Prior Year</b>	<b>Current Year 2018 Total Utilizing Beneficiaries</b>	<b>% Utilizing Beneficiaries with a Paid Claim</b>	<b>% Change Total Utilizing Beneficiaries Prior Year</b>
1	1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	5,509,138	0.5%	3,053,517	27.7%	0.1%
2	2	PENICILLIN ANTIBIOTICS	2,668,506	-1.0%	2,098,896	19.0%	-0.1%
3	5	ANTIHISTAMINES - 2ND GENERATION	2,958,842	3.6%	1,161,067	10.5%	0.1%
4	4	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	2,876,756	1.7%	1,149,762	10.4%	-0.1%
5	3	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	2,533,230	-15.3%	1,109,769	10.1%	-1.8%
6	6	TOPICAL ANTI-INFLAMMATORY STEROIDAL	1,701,790	2.9%	1,040,997	9.4%	0.2%
7	8	LAXATIVES AND CATHARTICS	1,876,801	0.3%	861,679	7.8%	0.0%
8	7	MACROLIDE ANTIBIOTICS	1,047,335	-6.1%	842,431	7.6%	-0.4%
9	10	ANTIEMETIC/ANTIVERTIGO AGENTS	1,126,936	1.8%	781,076	7.1%	0.2%
10	9	ANTIHISTAMINES - 1ST GENERATION	1,542,912	0.0%	766,539	7.0%	-0.1%
11	14	ANALGESIC/ANTIPYRETICS, NON-SALICYLATE	1,154,213	7.1%	763,707	6.9%	0.5%
12	13	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	3,780,135	3.2%	753,361	6.8%	0.3%
13	11	GLUCOCORTICOIDS	1,147,716	0.0%	752,876	6.8%	0.0%
14	12	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	881,122	-0.3%	733,271	6.7%	0.0%
15	16	ANTICONVULSANTS	3,752,135	2.9%	689,408	6.3%	0.2%
16	15	NASAL ANTI-INFLAMMATORY STEROIDS	1,430,715	4.4%	676,572	6.1%	0.0%
17	17	PROTON-PUMP INHIBITORS	2,371,847	-2.4%	638,074	5.8%	-0.2%
18	18	PLATELET AGGREGATION INHIBITORS	2,994,367	0.9%	602,146	5.5%	0.1%
19	20	VITAMIN D PREPARATIONS	2,311,767	14.3%	595,203	5.4%	0.5%
20	19	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	2,724,046	0.8%	570,933	5.2%	0.0%

**Table 4. Top 20 Drug Therapeutic Categories in the Medi-Cal Population, by Program.**

This table presents utilization of the top 20 drug therapeutic categories in the Medi-Cal program, by **total utilizing beneficiaries stratified by Medi-Cal program.**

<b>Table 4: Top 20 Drug Therapeutic Categories by <i>Total Utilizing Beneficiaries</i> for the Entire Medi-Cal Population, by Program</b>							
		<b>Current Year 2018</b>					
		<b>Total Paid Claims</b>			<b>Total Utilizing Beneficiaries</b>		
<b>Rank</b>	<b>Drug Therapeutic Category Description</b>	<b>All Medi-Cal</b>	<b>% FFS</b>	<b>% MCP</b>	<b>All Medi-Cal</b>	<b>% FFS</b>	<b>% MCP</b>
1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	5,509,138	5.8%	5.0%	3,053,517	22.9%	27.9%
2	PENICILLIN ANTIBIOTICS	2,668,506	3.1%	2.4%	2,098,896	13.4%	19.4%
3	ANTIHISTAMINES - 2ND GENERATION	2,958,842	2.5%	2.8%	1,161,067	5.4%	11.0%
4	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	2,876,756	2.5%	2.7%	1,149,762	7.1%	10.8%
5	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	2,533,230	2.5%	2.3%	1,109,769	9.8%	10.0%
6	TOPICAL ANTI-INFLAMMATORY STEROIDAL	1,701,790	1.4%	1.6%	1,040,997	5.3%	9.8%
7	LAXATIVES AND CATHARTICS	1,876,801	2.6%	1.7%	861,679	6.0%	7.9%
8	MACROLIDE ANTIBIOTICS	1,047,335	1.2%	1.0%	842,431	4.9%	7.9%
9	ANTIEMETIC/ANTIVERTIGO AGENTS	1,126,936	1.3%	1.0%	781,076	5.1%	7.2%
10	ANTIHISTAMINES - 1ST GENERATION	1,542,912	1.6%	1.4%	766,539	4.7%	7.1%
11	ANALGESIC/ANTIPYRETICS, NON-SALICYLATE	1,154,213	1.0%	1.1%	763,707	4.4%	7.2%
12	ANTIHYPERTENSIVE-HMGCOA REDUCTASE INHIB(STATINS)	3,780,135	2.6%	3.6%	753,361	5.2%	7.1%
13	GLUCOCORTICOIDS	1,147,716	1.3%	1.0%	752,876	4.8%	7.0%
14	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	881,122	1.4%	0.8%	733,271	6.4%	6.6%
15	ANTICONVULSANTS	3,752,135	4.2%	3.4%	689,408	5.8%	6.4%
16	NASAL ANTI-INFLAMMATORY STEROIDS	1,430,715	0.4%	1.4%	676,572	1.4%	6.7%
17	PROTON-PUMP INHIBITORS	2,371,847	1.2%	2.3%	638,074	2.5%	6.1%
18	PLATELET AGGREGATION INHIBITORS	2,994,367	3.2%	2.7%	602,146	5.6%	5.4%
19	VITAMIN D PREPARATIONS	2,311,767	0.2%	2.3%	595,203	0.4%	6.0%
20	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	2,724,046	2.2%	2.5%	570,933	4.0%	5.4%

**Table 5. Top 20 Drugs in the Medi-Cal Population.**

This table presents utilization of the top 20 drugs in the Medi-Cal program, by **total utilizing beneficiaries**. The current year is compared to the prior year in order to illustrate changes in utilization for these drugs. The prior year ranking of each drug is listed for reference.

Table 5: Top 20 Drugs by <i>Total Utilizing Beneficiaries</i> for the Entire Medi-Cal Population							
Rank	Last Year Rank	Drug Description	Current Year 2018 Total Paid Claims	% Change from Prior Year	Current Year 2018 Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries Prior Year
1	1	IBUPROFEN	4,031,128	0.9%	2,382,673	21.6%	0.3%
2	2	AMOXICILLIN	1,991,564	-1.6%	1,520,817	13.8%	-0.2%
3	3	ALBUTEROL SULFATE	2,910,977	1.4%	1,186,055	10.8%	-0.1%
4	5	LORATADINE	2,128,627	-0.4%	825,240	7.5%	-0.3%
5	6	AZITHROMYCIN	976,975	-6.3%	788,799	7.2%	-0.4%
6	8	ACETAMINOPHEN	1,154,223	7.1%	763,709	6.9%	0.5%
7	9	FLUTICASONE PROPIONATE	1,637,395	10.2%	752,746	6.8%	0.4%
8	4	HYDROCODONE/ ACETAMINOPHEN	1,864,209	-15.8%	748,724	6.8%	-1.1%
9	7	CEPHALEXIN	876,296	-0.4%	730,479	6.6%	0.0%
10	10	ASPIRIN	2,782,934	0.3%	572,120	5.2%	0.1%
11	11	PROMETHAZINE/ DEXTROMETHORPHAN	665,584	1.7%	494,856	4.5%	0.0%
12	19	ATORVASTATIN CALCIUM	2,315,955	16.1%	474,269	4.3%	0.6%
13	12	TRIAMCINOLONE ACETONIDE	762,615	2.7%	465,498	4.2%	0.1%
14	13	METFORMIN HCL	2,358,792	-1.2%	446,652	4.1%	0.0%
15	18	AMOXICILLIN/ POTASSIUM CLAV	507,070	3.6%	433,714	3.9%	0.1%
16	14	OMEPRAZOLE	1,614,932	-3.3%	430,319	3.9%	-0.1%
17	15	FERROUS SULFATE	1,090,362	2.7%	423,694	3.8%	-0.1%
18	16	DOCUSATE SODIUM	1,083,651	-3.1%	415,743	3.8%	-0.1%
19	17	DIPHENHYDRAMINE HCL	752,769	-4.8%	407,913	3.7%	-0.2%
20	20	PREDNISONE	681,488	1.0%	402,970	3.7%	0.1%

**Table 6. Top 20 Drugs in the Medi-Cal Population, by Program.**

This table presents utilization of the top 20 drug therapeutic categories in the Medi-Cal program, by **total utilizing beneficiaries stratified by Medi-Cal program**.

Table 6: Top 20 Drugs by <i>Total Utilizing Beneficiaries</i> for the Entire Medi-Cal Population, by Program							
		Current Year 2018					
		Total Paid Claims			Total Utilizing Beneficiaries		
Rank	Medi-Cal	Medi-Cal	% FFS	% MCP	Medi-Cal	% FFS	% MCP
1	IBUPROFEN	4,031,128	4.8%	3.7%	2,382,673	19.0%	21.7%
2	AMOXICILLIN	1,991,564	2.2%	1.8%	1,520,817	9.3%	14.1%
3	ALBUTEROL SULFATE	2,910,977	2.5%	2.7%	1,186,055	7.4%	11.1%
4	LORATADINE	2,128,627	2.4%	1.9%	825,240	5.3%	7.7%
5	AZITHROMYCIN	976,975	1.0%	0.9%	788,799	4.5%	7.4%
6	ACETAMINOPHEN	1,154,223	1.0%	1.1%	763,709	4.4%	7.2%
7	FLUTICASONE PROPIONATE	1,637,395	0.6%	1.6%	752,746	1.8%	7.4%
8	HYDROCODONE/ ACETAMINOPHEN	1,864,209	1.8%	1.7%	748,724	6.9%	6.7%
9	CEPHALEXIN	876,296	1.4%	0.8%	730,479	6.4%	6.5%
10	ASPIRIN	2,782,934	3.1%	2.5%	572,120	5.3%	5.1%
11	PROMETHAZINE/ DEXTROMETHORPHAN	665,584	0.9%	0.6%	494,856	3.3%	4.6%
12	ATORVASTATIN CALCIUM	2,315,955	1.7%	2.2%	474,269	3.5%	4.5%
13	TRIAMCINOLONE ACETONIDE	762,615	0.6%	0.7%	465,498	2.0%	4.4%
14	METFORMIN HCL	2,358,792	2.3%	2.2%	446,652	4.4%	4.1%
15	AMOXICILLIN/ POTASSIUM CLAV	507,070	0.6%	0.5%	433,714	2.9%	4.0%
16	OMEPRAZOLE	1,614,932	0.9%	1.6%	430,319	1.6%	4.3%
17	FERROUS SULFATE	1,090,362	2.2%	0.9%	423,694	6.1%	3.5%
18	DOCUSATE SODIUM	1,083,651	2.3%	0.9%	415,743	5.6%	3.5%
19	DIPHENHYDRAMINE HCL	752,769	0.9%	0.7%	407,913	2.3%	3.8%
20	PREDNISONE	681,488	0.9%	0.6%	402,970	3.3%	3.7%

**QUARTERLY SUMMARY**  
**MEDI-CAL FEE-FOR-SERVICE PROGRAM DRUG USE REVIEW**  
**REPORT PERIOD: 1<sup>ST</sup> QUARTER 2019 (JANUARY – MARCH 2019)**

**Executive Summary**

The DUR quarterly report provides information on both prospective and retrospective drug utilization for all claims processed by the Medi-Cal Fee-for-Service (FFS) program, including the carved-out drug claims for the Medi-Cal Managed Care Plans (MCPs). For this quarterly report, the prospective and retrospective data cover the first quarter of 2019 (2019 Q1). All tables can be found in **Appendix A** and definitions of selected terms can be found in **Appendix B**.

***Prospective DUR***

As shown in Table 1.1, in comparison to the prior quarter (2018 Q4), in 2019 Q1 overall drug claims increased by 3%, while total DUR alerts increased by < 1%. In comparison to the prior-year quarter (2018 Q1), overall drug claims decreased by 4% while total DUR alerts decreased by 2%. A comparison between 2019 Q1 and 2018 Q4 showed very little change among the summary of alert transactions by therapeutic problem (**Table 1.2**) and among the top 10 drugs for each of the 12 prospective DUR alerts (**Tables 2.1-2.12**).

***Retrospective DUR***

Due to a slight lag in processing time, the aggregate tables contain complete retrospective claims data, while the stratified tables are not yet complete for 2019 Q1. For this report, the stratified tables represent 95.4% of total paid claims represented in the aggregated tables.

In 2019 Q1, approximately 15% of eligible Medi-Cal FFS enrollees had a paid claim through the Medi-Cal fee-for-service program, compared with only 2% of Medi-Cal MCP enrollees (**Table 3.2** and **Table 3.3**). Among all Medi-Cal beneficiaries with a paid claim through the Medi-Cal fee-for-service program in 2019 Q1, 56% were FFS enrollees and 35% were MCP enrollees (numbers add up to less than 100% due to the lag in processing time).

As shown in **Table 4.1**, total paid claims decreased across all age groups in comparison to the prior-year quarter. The greatest decrease in utilizing beneficiaries and paid claims processed by the FFS program in comparison to the prior-year quarter was in the FFS population (**Table 4.2**). A review of fee-for-service paid claims for the Medi-Cal MCP population (**Table 4.3**) shows that in comparison to the prior-year quarter, there was an increase in total utilizing beneficiaries and total paid claims in all three of the adult age groups.

Of note, **Table 5.2** and **Table 6.2** show the top 20 drug therapeutic drug categories and top 20 drugs of Medi-Cal FFS program enrollees, while **Table 5.3** and **Table 6.3** show the top 20 drug therapeutic drug categories and top 20 drugs by beneficiaries enrolled in Medi-Cal MCPs. These tables give a more in-depth look at the impact of carved-out drugs on tables showing overall pharmacy utilization in the Medi-Cal fee-for-service program (**Table 5.1** and **Table 6.1**). **Table 6.3** shows significant across-the-board increases in the MCP population during 2019 Q1 for NALOXONE, which was the subject of California legislation that became effective the first day of 2019 Q1 and BICTEGRAVIR/EMTRICITABINE/TENOFOVIR ALAFENAMIDE, which was approved by the FDA during 2018 Q1.

## Appendix A: Prospective and Retrospective DUR Tables

### Tables 1.1-1.2. Summary of Prospective DUR Alert Transactions in the Medi-Cal Fee-for-Service Program..

**Table 1.1** provides summary level data (by volume) on pharmacy claims and DUR alert activities, including data and percent change from the prior quarter. Alerts are generated after adjudication of drug claims which exceed or otherwise fall outside of certain prescribed parameters. Please see **Appendix B** for definitions of terms used in this DUR report.

Category	Current Quarter 2019 Q1 (Jul – Sept 2019)	Prior Quarter 2018 Q4 (Apr – Jun 2019)	% Change from Prior Quarter	Prior-Year Quarter 2018 Q1 (Jul – Sept 2018)	% Change from Prior-Year Quarter
Drug Claims	8,000,439	7,760,490	3.1%	8,324,737	-3.9%
DUR Drug Claims	3,753,849	3,714,099	1.1%	4,000,078	-6.2%
Total Alerts	1,054,056	1,049,489	0.4%	1,079,784	-2.4%
Total Alert Overrides	680,252	675,741	0.7%	679,372	0.1%
Total Alert Cancels	276	254	8.7%	235	17.4%

Note: Drug claims receiving multiple alerts can be adjudicated by pharmacists by responding to only one conflict code, followed by an intervention code and outcome code. The remaining alerts on the claim cannot be tracked as they are overridden by the pharmacist's response to a single alert. For example, a single claim can generate up to eight different alerts, but the pharmacist can override all eight alerts by choosing to override only one alert. In addition, the number of cancelled alerts may be underrepresented due to the system's inability to capture claims that were not adjudicated.

**Table 1.2** provides a summary of the number of drug claims and alerts generated for each therapeutic problem type (sorted by alert frequency). Total alerts not adjudicated may be overrepresented, as claims with multiple alerts that have been adjudicated under one alert will show up as not adjudicated for the remaining alerts.

Therapeutic Problem Type	Total Alerts	Total Alert Overrides	% Alert Overrides	Total Alert Cancels	% Alert Cancels	Total Alerts Not Adjudicated	% Alerts Not Adjudicated
Therapeutic Duplication (TD)	324,644	248,019	76.4%	57	0.0%	76,568	23.6%
Early Refill (ER)	279,368	98,508	35.3%	103	0.0%	180,757	64.7%
Ingredient Duplication (ID)	222,510	164,235	73.8%	32	0.0%	58,243	26.2%
Late Refill (LR)	106,782	83,936	78.6%	43	0.0%	22,803	21.4%
Total High Dose (HD)	47,314	30,586	64.6%	12	0.0%	16,716	35.3%
Additive Toxicity (AT)	32,951	26,954	81.8%	10	0.0%	5,987	18.2%
Drug-Pregnancy (PG)	19,908	13,367	67.1%	4	0.0%	6,537	32.8%
Total Low Dose (LD)	12,110	8,228	67.9%	4	0.0%	3,878	32.0%
Drug-Drug (DD)	5,720	4,428	77.4%	0	0.0%	1,292	22.6%
Drug-Disease (MC)	2,298	1,700	74.0%	0	0.0%	598	26.0%
Drug-Age (PA)	308	197	64.0%	0	0.0%	111	36.0%
Drug-Allergy (DA)	143	95	66.4%	0	0.0%	48	33.6%

**Tables 2.1-2.12. Prospective DUR Alert Transactions by Therapeutic Problem Type in the Medi-Cal Fee-for-Service Program.**

Each of the following tables provides greater detail of each of the 12 DUR alerts with the top 10 drugs generating each respective alert. For each of the top 10 drugs, data are provided for the total number of adjudicated alerts, alert overrides, alert cancels, paid claims, and the percentage of paid claims with alert overrides. **Tables are listed in order of DUR alert priority, which is determined by the DUR Board.**

<b>Table 2.1: Top 10 Drugs by Therapeutic Problem Type – Drug-Allergy (DA) – 2019 Q1</b>						
<b>Rank</b>	<b>Drug Generic Name/Ingredient Name</b>	<b>Total Adjudicated Alerts</b>	<b>Total Alert Overrides</b>	<b>Total Alert Cancels</b>	<b>Total Paid Claims</b>	<b>% of Paid Claims with Alert Overrides</b>
1	PHENYTOIN SODIUM EXTENDED	68	68	0	1,609	4.2%
2	PHENYTOIN	23	23	0	680	3.4%
3	OXYCODONE HCL	12	12	0	3,815	0.3%
4	BUPRENORPHINE HCL/ NALOXONE HCL	7	7	0	40,368	0.0%
5	OXYCODONE HCL/ACETAMINOPHEN	5	5	0	3,919	0.1%
6	AMANTADINE HCL	3	3	0	2,865	0.1%
7	ARIPIPIRAZOLE	3	3	0	103,479	0.0%
8	ETOPOSIDE	3	3	0	6	50.0%
9	IBUPROFEN	3	3	0	87,811	0.0%
10	QUETIAPINE FUMARATE	3	3	0	138,991	0.0%

<b>Table 2.2: Top 10 Drugs by Therapeutic Problem Type – Drug-Pregnancy (PG) – 2019 Q1</b>						
<b>Rank</b>	<b>Drug Generic Name/Ingredient Name</b>	<b>Total Adjudicated Alerts</b>	<b>Total Alert Overrides</b>	<b>Total Alert Cancels</b>	<b>Total Paid Claims</b>	<b>% of Paid Claims with Alert Overrides</b>
1	IBUPROFEN	12,898	12,894	4	87,811	14.7%
2	NORETHINDRONE	2,243	2,243	0	7,021	31.9%
3	MISOPROSTOL	410	410	0	542	75.6%
4	NAPROXEN	274	274	0	12,233	2.2%
5	METHYLERGONOVINE MALEATE	247	247	0	145	170.3%
6	METHIMAZOLE	154	154	0	1,449	10.6%
7	LISINAPRIL	123	123	0	32,406	0.4%
8	FERROUS SULFATE	115	115	0	36,191	0.3%
9	ULIPRISTAL ACETATE	103	103	0	716	14.4%
10	DOCUSATE SODIUM	76	76	0	36,317	0.2%

<b>Table 2.3: Top 10 Drugs by Therapeutic Problem Type – Drug-Disease (MC) – 2019 Q1</b>						
<b>Rank</b>	<b>Drug Generic Name/Ingredient Name</b>	<b>Total Adjudicated Alerts</b>	<b>Total Alert Overrides</b>	<b>Total Alert Cancels</b>	<b>Total Paid Claims</b>	<b>% of Paid Claims with Alert Overrides</b>
1	METFORMIN HCL	386	386	0	40,833	0.9%
2	POTASSIUM CHLORIDE	346	345	1	3,041	11.3%
3	HALOPERIDOL	285	285	0	18,067	1.6%
4	PROPRANOLOL HCL	126	126	0	4,097	3.1%
5	METOPROLOL TARTRATE	62	62	0	6,848	0.9%
6	LEVONORGESTREL-ETHIN ESTRADIOL	61	61	0	14,250	0.4%
7	CARBAMAZEPINE	60	60	0	2,764	2.2%
8	METOPROLOL SUCCINATE	48	48	0	6,443	0.7%
9	HALOPERIDOL DECANOATE	44	44	0	4,284	1.0%
10	NORGESTIMATE-ETHINYL ESTRADIOL	39	39	0	15,054	0.3%

**Table 2.4: Top 10 Drugs by Therapeutic Problem Type – Drug-Drug Interaction (DD) – 2019 Q1**

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	ELVITEG/COB/EMTRI/TENOF ALAFEN	581	581	0	11,095	5.2%
2	DARUNAVIR ETHANOLATE	540	540	0	2,865	18.8%
3	GEMFIBROZIL	461	461	0	1,960	23.5%
4	ATORVASTATIN CALCIUM	304	304	0	31,276	1.0%
5	SIMVASTATIN	274	274	0	8,772	3.1%
6	AMLODIPINE BESYLATE	182	182	0	21,787	0.8%
7	DARUNAVIR/COBICISTAT	123	123	0	4,219	2.9%
8	ETRAVIRINE	108	108	0	623	17.3%
9	LURASIDONE HCL	105	105	0	40,887	0.3%
10	BUPRENORPHINE HCL/ NALOXONE HCL	84	84	0	40,368	0.2%

**Table 2.5: Top 10 Drugs by Therapeutic Problem Type – Therapeutic Duplication (TD) – 2019 Q1**

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	39,567	39,557	10	138,991	28.5%
2	OLANZAPINE	28,522	28,513	9	81,093	35.2%
3	ARIPIRAZOLE	23,708	23,705	3	103,479	22.9%
4	RISPERIDONE	20,527	20,524	3	80,998	25.3%
5	HALOPERIDOL	14,459	14,457	2	18,067	80.0%
6	LURASIDONE HCL	13,376	13,367	9	40,887	32.7%
7	CLOZAPINE	11,905	11,903	2	20,704	57.5%
8	PALIPERIDONE PALMITATE	8,276	8,275	1	19,222	43.0%
9	CHLORPROMAZINE HCL	5,842	5,842	0	6,047	96.6%
10	ZIPRASIDONE HCL	5,100	5,100	0	15,691	32.5%

**Table 2.6: Top 10 Drugs by Therapeutic Problem Type – Overutilization (ER) – 2019 Q1**

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	8,729	8,723	6	138,991	6.3%
2	ARIPIRAZOLE	6,163	6,160	3	103,479	6.0%
3	OLANZAPINE	5,158	5,156	2	81,093	6.4%
4	RISPERIDONE	4,745	4,742	3	80,998	5.9%
5	BENZTROPINE MESYLATE	3,918	3,916	2	54,209	7.2%
6	LITHIUM CARBONATE	2,722	2,722	0	29,204	9.3%
7	LURASIDONE HCL	2,424	2,420	4	40,887	5.9%
8	BUPRENORPHINE HCL/ NALOXONE HCL	2,001	2,001	0	40,368	5.0%
9	METFORMIN HCL	1,932	1,929	3	40,833	4.7%
10	ALBUTEROL SULFATE	1,796	1,796	0	50,501	3.6%

**Table 2.7: Top 10 Drugs by Therapeutic Problem Type – Underutilization (LR) – 2019 Q1**

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	ARIPIRAZOLE	14,223	14,222	1	103,479	13.7%
2	QUETIAPINE FUMARATE	13,623	13,619	4	138,991	9.8%
3	RISPERIDONE	8,488	8,484	4	80,998	10.5%
4	OLANZAPINE	7,285	7,285	0	81,093	9.0%
5	BENZTROPINE MESYLATE	6,092	6,092	0	54,209	11.2%
6	LURASIDONE HCL	4,950	4,950	0	40,887	12.1%
7	LITHIUM CARBONATE	3,902	3,899	3	29,204	13.4%
8	ATORVASTATIN CALCIUM	3,060	3,055	5	31,276	9.8%
9	LEVOTHYROXINE SODIUM	3,021	3,015	6	23,833	12.7%
10	GABAPENTIN	2,460	2,459	1	23,119	10.6%

**Table 2.8: Top 10 Drugs by Therapeutic Problem Type – Additive Toxicity (AT) – 2019 Q1**

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	LITHIUM CARBONATE	1,490	1,490	0	29,204	5.1%
2	LORAZEPAM	1,335	1,335	0	7,032	19.0%
3	CLONAZEPAM	1,097	1,097	0	6,014	18.2%
4	BACLOFEN	1,035	1,035	0	12,947	8.0%
5	QUETIAPINE FUMARATE	1,004	1,003	1	138,991	0.7%
6	HYDROCODONE/ACETAMINOPHEN	829	829	0	24,143	3.4%
7	ARIPIRAZOLE	624	623	1	103,479	0.6%
8	TRAZODONE HCL	549	549	0	10,711	5.1%
9	OLANZAPINE	534	533	1	81,093	0.7%
10	BUSPIRONE HCL	512	511	1	3,370	15.2%

**Table 2.9: Top 10 Drugs by Therapeutic Problem Type – Ingredient Duplication (ID) – 2019 Q1**

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	28,486	28,478	8	138,991	20.5%
2	OLANZAPINE	15,430	15,430	0	81,093	19.0%
3	ARIPIRAZOLE	12,331	12,330	1	103,479	11.9%
4	RISPERIDONE	11,152	11,152	0	80,998	13.8%
5	ALBUTEROL SULFATE	8,606	8,605	1	50,501	17.0%
6	LURASIDONE HCL	6,302	6,301	1	40,887	15.4%
7	CLOZAPINE	6,179	6,179	0	20,704	29.8%
8	ZIPRASIDONE HCL	3,133	3,131	2	15,691	20.0%
9	LEVOTHYROXINE SODIUM	3,088	3,086	2	23,833	12.9%
10	BENZTROPINE MESYLATE	2,379	2,378	1	54,209	4.4%

**Table 2.10: Top 10 Drugs by Therapeutic Problem Type – Drug-Age (PA) – 2019 Q1**

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	AMITRIPTYLINE HCL	168	167	1	3,178	5.3%
2	ACETAMINOPHEN WITH CODEINE	41	41	0	5,730	0.7%
3	ARIPIRAZOLE	16	16	0	103,479	0.0%
4	DOXEPIN HCL	13	13	0	435	3.0%
5	CODEINE PHOSPHATE/GUAIFENESIN	10	10	0	4,468	0.2%
6	QUETIAPINE FUMARATE	9	9	0	138,991	0.0%
7	LURASIDONE HCL	7	7	0	40,887	0.0%
8	OLANZAPINE	5	5	0	81,093	0.0%
9	BENZTROPINE MESYLATE	4	4	0	54,209	0.0%
10	RISPERIDONE	4	4	0	80,998	0.0%

**Table 2.11: Top 10 Drugs by Therapeutic Problem Type – High Dose (HD) – 2019 Q1**

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	OLANZAPINE	7,213	7,213	0	81,093	8.9%
2	IBUPROFEN	2,608	2,607	1	87,811	3.0%
3	RISPERIDONE	2,093	2,091	2	80,998	2.6%
4	QUETIAPINE FUMARATE	1,444	1,444	0	138,991	1.0%
5	AMOXICILLIN	1,337	1,337	0	41,825	3.2%
6	GABAPENTIN	1,307	1,303	4	23,119	5.6%
7	AMOXICILLIN/POTASSIUM CLAV	1,135	1,135	0	13,043	8.7%
8	HYDROCODONE/ACETAMINOPHEN	894	894	0	24,143	3.7%
9	ARIPIRAZOLE	637	637	0	103,479	0.6%
10	FAMOTIDINE	508	508	0	13,221	3.8%

**Table 2.12: Top 10 Drugs by Therapeutic Problem Type – Low Dose (LD) – 2019 Q1**

Rank	Rank	Rank	Rank	Rank	Rank	Rank
1	AZITHROMYCIN	981	981	0	26,010	3.8%
2	DIVALPROEX SODIUM	691	691	0	10,536	6.6%
3	LITHIUM CARBONATE	575	575	0	29,204	2.0%
4	DULOXETINE HCL	498	498	0	4,142	12.0%
5	ERYTHROMYCIN ETHYLSUCCINATE	486	485	1	1,810	26.8%
6	AMOXICILLIN/POTASSIUM CLAV	470	470	0	13,043	3.6%
7	ALBUTEROL SULFATE	422	422	0	50,501	0.8%
8	BUPROPION HCL	329	329	0	5,770	5.7%
9	AMOXICILLIN	312	312	0	41,825	0.7%
10	SULFAMETHOXAZOLE/TRIMETHOPRIM	204	204	0	15,265	1.3%

### Tables 3.1-3.3. Summary of Medi-Cal Fee-for-Service Pharmacy Utilization.

These tables show pharmacy utilization in the Medi-Cal Fee-for-Service program, including the percent change from the prior quarter and prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted in both **Table 3.2** and **Table 3.3**, as enrollment status may change.

<b>Table 3.1: Fee-for-Service Pharmacy Utilization Measures for the Entire Medi-Cal Population</b>					
<b>Category</b>	<b>Current Quarter 2019 Q1</b>	<b>Prior Quarter 2018 Q4</b>	<b>Prior-Year Quarter 2018 Q1</b>	<b>% Change from <i>Prior Quarter</i></b>	<b>% Change from <i>Prior- Year Quarter</i></b>
Total Eligible Beneficiaries	15,300,073	15,585,544	15,804,637	-1.8%	-3.2%
Total Utilizing Beneficiaries	815,347	787,056	861,684	3.6%	-5.4%
Total Paid Rx Claims	2,682,194	2,620,546	2,851,378	2.4%	-5.9%
Average Paid Rx Claims per Eligible Beneficiary	0.18	0.17	0.18	4.3%	-2.8%
Average Paid Rx Claims per Utilizing Beneficiary	3.29	3.33	3.31	-1.2%	-0.6%

<b>Table 3.2: Fee-for-Service Pharmacy Utilization Measures for the Medi-Cal FFS Population Only*</b>					
<b>Category</b>	<b>Current Quarter 2019 Q1</b>	<b>Prior Quarter 2018 Q4</b>	<b>Prior-Year Quarter 2018 Q1</b>	<b>% Change from <i>Prior Quarter</i></b>	<b>% Change from <i>Prior- Year Quarter</i></b>
Total Eligible Beneficiaries	3,109,951	3,179,837	3,338,040	-2.2%	-6.8%
Total Utilizing Beneficiaries	457,822	445,438	504,117	2.8%	-9.2%
Total Paid Rx Claims	1,646,307	1,587,376	1,771,194	3.7%	-7.1%
Average Paid Rx Claims per Eligible Beneficiary	0.53	0.50	0.53	6.0%	-0.2%
Average Paid Rx Claims per Utilizing Beneficiary	3.60	3.56	3.51	0.9%	2.3%

\*Complete (100%) utilization data for this stratified table is not yet available.

<b>Table 3.3: Fee-for-Service Pharmacy Utilization Measures for the Medi-Cal MCP Population Only*</b>					
<b>Category</b>	<b>Current Quarter 2019 Q1</b>	<b>Prior Quarter 2018 Q4</b>	<b>Prior-Year Quarter 2018 Q1</b>	<b>% Change from <i>Prior Quarter</i></b>	<b>% Change from <i>Prior- Year Quarter</i></b>
Total Eligible Beneficiaries	12,585,693	12,810,042	12,917,776	-1.4%	-2.1%
Total Utilizing Beneficiaries	285,452	275,889	272,643	3.5%	4.7%
Total Paid Rx Claims	914,252	918,860	915,010	-0.1%	1.9%
Average Paid Rx Claims per Eligible Beneficiary	0.07	0.07	0.07	1.3%	4.1%
Average Paid Rx Claims per Utilizing Beneficiary	3.20	3.33	3.36	-3.8%	-4.6%

\*Complete (100%) utilization data for this stratified table is not yet available.

### Tables 4.1-4.3. Fee-for-Service Pharmacy Utilization by Age Group in the Medi-Cal Population.

These tables present pharmacy utilization data in the Medi-Cal Fee-for-Service program, broken out by age group, including the percent change from the prior quarter and prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted in both **Table 4.2** and **Table 4.3**, as enrollment status may change.

Table 4.1: Fee-for-Service Pharmacy Utilization by Age Group for the Entire Medi-Cal Population						
Age Group (years)	Current Quarter 2019 Q1 Total Paid Claims	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>	Current Quarter Total Utilizing Beneficiaries	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>
0 – 12	302,986	10.3%	-12.9%	98,803	13.3%	-11.7%
13 – 18	176,857	2.1%	-6.8%	46,322	3.8%	-5.3%
19 – 39	817,488	2.4%	-2.8%	265,403	2.8%	-3.0%
40 – 64	1,115,449	1.9%	-3.2%	292,791	4.7%	0.5%
65+	194,822	-0.7%	-9.7%	64,812	-0.2%	-10.3%
Total	2,682,194	2.4%	-5.9%	815,347	3.6%	-5.4%

Table 4.2: Fee-for-Service Pharmacy Utilization by Age Group for the Medi-Cal FFS Population Only*						
Age Group (years)	Current Quarter 2019 Q1 Total Paid Claims	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>	Current Quarter Total Utilizing Beneficiaries	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>
0 – 12	202,314	19.0%	-11.3%	77,369	19.1%	-10.6%
13 – 18	96,472	6.3%	-5.7%	26,009	8.3%	-4.8%
19 – 39	466,963	2.9%	-6.9%	151,495	2.6%	-7.2%
40 – 64	694,963	1.8%	-5.1%	151,693	3.3%	-4.0%
65+	185,595	-2.4%	-10.3%	61,256	-1.2%	-11.2%
Total	1,646,307	3.7%	-7.1%	467,822	5.0%	-7.2%

\*Complete (100%) utilization data for this stratified table is not yet available.

Table 4.3: Fee-for-Service Pharmacy Utilization by Age Group for the Medi-Cal MCP Population Only*						
Age Group (years)	Current Quarter 2019 Q1 Total Paid Claims	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>	Current Quarter Total Utilizing Beneficiaries	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>
0 – 12	87,784	-5.0%	-12.2%	19,348	-4.6%	-11.4%
13 – 18	75,940	-4.0%	-7.2%	19,960	-2.9%	-4.8%
19 – 39	331,499	0.7%	5.1%	106,021	3.3%	7.4%
40 – 64	409,598	0.2%	0.2%	136,608	5.9%	6.8%
65+	9,431	1.0%	7.3%	3,515	3.6%	10.9%
Total	914,252	-0.5%	-0.1%	285,452	3.5%	4.7%

\*Complete (100%) utilization data for this stratified table is not yet available.

### Tables 5.1-5.3. Top 20 Fee-for-Service Drug Therapeutic Categories in the Medi-Cal Population.

These tables present utilization of the top 20 drug therapeutic categories in the Medi-Cal Fee-for-Service program, by **total utilizing beneficiaries**. The current quarter is compared to the prior quarter and prior-year quarter in order to illustrate changes in utilization and reimbursement dollars paid to pharmacies for these top utilized drugs. The prior-year quarter ranking of the drug therapeutic category is listed for reference.

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2019 Q1 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST	408,120	-0.3%	0.8%	139,307	17.1%	-0.4%	1.0%
2	2	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	105,678	11.0%	-4.5%	90,570	11.1%	0.8%	0.1%
3	4	PENICILLIN ANTIBIOTICS	59,281	26.1%	-10.2%	53,606	6.6%	1.2%	-0.3%
4	3	CONTRACEPTIVES, ORAL	69,820	-4.5%	-18.0%	51,667	6.3%	-0.7%	-1.2%
5	5	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	109,559	-0.3%	2.4%	47,837	5.9%	-0.1%	0.5%
6	6	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	50,729	17.0%	-11.9%	36,119	4.4%	0.7%	-0.4%
7	7	PLATELET AGGREGATION INHIBITORS	49,919	-1.8%	-10.9%	34,138	4.2%	-0.1%	-0.2%
8	9	ANTICONVULSANTS	83,473	-0.9%	-6.2%	31,871	3.9%	-0.1%	0.0%
9	13	ANTIHYPERTENSIVE-HMGCOA REDUCTASE INHIB (STATINS)	44,768	2.3%	-2.0%	30,220	3.7%	0.0%	0.2%
10	14	ANTIHYPERTENSIVES, ACE INHIBITORS	43,479	2.4%	-4.8%	29,028	3.6%	0.0%	0.1%
11	10	ANTIHISTAMINES - 2ND GENERATION	40,230	4.3%	-11.4%	27,882	3.4%	0.2%	-0.2%
12	16	ANTIHYPERTENSIVE, BIGUANIDE TYPE	40,833	2.9%	-1.5%	27,595	3.4%	0.0%	0.2%
13	11	IRON REPLACEMENT	36,304	0.2%	-11.2%	27,579	3.4%	0.0%	-0.2%
14	12	LAXATIVES AND CATHARTICS	41,899	-3.3%	-10.1%	27,546	3.4%	-0.2%	-0.2%
15	8	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	33,792	-6.0%	-24.7%	27,110	3.3%	-0.3%	-0.9%
16	15	MACROLIDE ANTIBIOTICS	29,195	29.1%	-11.6%	25,957	3.2%	0.7%	-0.2%
17	73	OPIOID ANTAGONISTS	27,387	125.8%	269.6%	23,645	2.9%	1.7%	2.3%
18	18	ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC	58,606	-0.9%	-3.3%	23,171	2.8%	-0.1%	0.1%
19	27	ANTIEMETIC/ANTIVERTIGO AGENTS	27,826	10.2%	12.6%	22,487	2.8%	0.2%	0.5%
20	19	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	23,815	1.1%	-4.2%	22,363	2.7%	-0.1%	0.0%

**Table 5.2: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Medi-Cal FFS Population Only**

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2019 Q1 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	103,898	11.0%	-4.1%	91,272	19.5%	11.5%	-4.3%
2	2	PENICILLIN ANTIBIOTICS	58,032	26.5%	-9.5%	53,939	11.5%	26.9%	-9.5%
3	3	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	46,800	18.7%	-11.9%	34,287	7.3%	24.0%	-13.6%
4	4	PLATELET AGGREGATION INHIBITORS	48,939	-2.4%	-10.7%	34,206	7.3%	0.2%	-9.3%
5	6	ANTICONVULSANTS	68,178	-0.8%	-5.3%	33,211	7.1%	2.1%	-4.0%
6	8	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	44,190	1.3%	-1.7%	30,024	6.4%	4.3%	0.7%
7	5	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	33,304	-6.1%	-24.1%	27,404	5.9%	-6.3%	-25.0%
8	11	ANTIHYPERTENSIVES, ACE INHIBITORS	40,073	2.1%	-4.2%	27,324	5.8%	4.6%	-2.1%
9	7	ANTIHISTAMINES - 2ND GENERATION	39,057	4.0%	-11.8%	27,268	5.8%	9.9%	-10.2%
10	10	IRON REPLACEMENT	34,946	0.2%	-9.3%	26,776	5.7%	2.9%	-8.0%
11	9	LAXATIVES AND CATHARTICS	39,541	-4.0%	-10.0%	26,676	5.7%	-2.8%	-9.6%
12	12	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	38,411	2.1%	-1.4%	26,366	5.6%	4.4%	0.7%
13	20	ANTIEMETIC/ANTIVERTIGO AGENTS	26,675	10.9%	15.0%	23,388	5.0%	12.9%	18.9%
14	13	MACROLIDE ANTIBIOTICS	24,505	37.2%	-11.0%	22,187	4.7%	40.1%	-11.2%
15	15	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	22,686	1.3%	-3.1%	21,345	4.6%	1.4%	-3.1%
16	17	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	36,351	0.5%	-2.6%	20,654	4.4%	2.1%	-2.3%
17	14	GLUCOCORTICOIDS	24,734	19.2%	-8.4%	20,584	4.4%	22.3%	-9.3%
18	16	PRENATAL VITAMIN PREPARATIONS	21,725	7.9%	-10.0%	19,495	4.2%	8.4%	-9.2%
19	18	ANTIHISTAMINES - 1ST GENERATION	26,060	4.0%	-8.0%	19,370	4.1%	6.9%	-6.8%
20	19	TOPICAL ANTI-INFLAMMATORY STEROIDAL	20,815	1.7%	-9.6%	18,107	3.9%	2.3%	-9.5%

**Table 5.3: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Medi-Cal MCP Population Only**

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2019 Q1 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST	371,861	-0.6%	1.1%	143,313	50.2%	1.3%	0.7%
2	2	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	100,864	-0.9%	2.4%	44,466	15.6%	1.2%	3.0%
3	13	OPIOID ANTAGONISTS	25,014	125.6%	275.3%	21,709	7.6%	153.3%	359.9%
4	3	ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC	53,539	-1.3%	-2.8%	21,288	7.5%	0.3%	-2.7%
5	6	OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE	44,247	5.5%	27.0%	13,938	4.9%	7.0%	24.4%
6	4	BIPOLAR DISORDER DRUGS	26,884	-1.3%	-3.6%	11,254	3.9%	0.4%	-4.1%
7	5	INSULINS	20,656	-6.3%	-9.8%	10,252	3.6%	-6.6%	-10.2%
8	7	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	20,895	-8.4%	-15.4%	9,980	3.5%	-4.8%	-9.8%
9	10	ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS	22,019	2.6%	50.8%	9,404	3.3%	6.2%	49.2%
10	8	ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES	21,324	-5.2%	-8.4%	8,528	3.0%	-2.7%	-4.9%
11	9	ANTICONVULSANTS	15,252	-7.8%	-9.6%	6,303	2.2%	-7.5%	-10.3%
12	12	ANTIPSYCHOTICS, PHENOTHIAZINES	11,651	-2.4%	-6.4%	4,394	1.5%	-0.4%	-7.7%
13	11	ANTIVIRALS, HIV-1 INTEGRASE STRAND TRANSFER INHIBITR	10,070	-8.6%	-21.4%	4,389	1.5%	-5.3%	-17.5%
14	14	ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB	8,769	-9.9%	-20.0%	3,672	1.3%	-5.4%	-16.4%
15	17	OPIOID ANALGESICS	5,665	-2.8%	-6.0%	2,881	1.0%	-3.7%	-7.5%
16	15	ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB	6,613	-10.6%	-28.4%	2,849	1.0%	-5.3%	-24.8%
17	16	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	6,183	-17.7%	-30.7%	2,633	0.9%	-14.2%	-27.5%
18	18	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	4,191	-9.6%	-25.5%	2,005	0.7%	-4.4%	-20.3%
19	19	ANTICONVULSANT - BENZODIAZEPINE TYPE	4,366	-5.3%	-6.3%	1,982	0.7%	-4.7%	-5.4%
20	21	VITAMIN D PREPARATIONS	3,443	-1.0%	-4.4%	1,957	0.7%	0.5%	-4.9%

**Tables 6.1-6.3. Top 20 Fee-for-Service Drugs in the Medi-Cal Population.**

These tables present the utilization of the top 20 drugs in the Medi-Cal Fee-for-Service program, by **total utilizing beneficiaries**. The current quarter is compared to the prior quarter and prior-year quarter in order to illustrate changes in utilization for these drugs. The prior-year quarter ranking of each drug is listed for reference.

**Table 6.1: Top 20 Fee-for-Service Drugs by Total Utilizing Beneficiaries for the Entire Medi-Cal Population**

Rank	Last Year Rank	Drug Description	Current Quarter 2019 Q1 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	IBUPROFEN	87,811	12.7%	-4.2%	77,752	9.5%	0.8%	0.1%
2	2	QUETIAPINE FUMARATE	138,991	-0.1%	0.1%	53,643	6.6%	-0.1%	0.3%
3	3	ARIPIRAZOLE	103,479	-0.3%	1.2%	45,363	5.6%	-0.1%	0.4%
4	4	AMOXICILLIN	41,825	27.5%	-11.7%	38,592	4.7%	0.9%	-0.3%
5	5	ALBUTEROL SULFATE	50,501	19.0%	-12.4%	36,629	4.5%	0.8%	-0.5%
6	6	ASPIRIN	47,244	-2.7%	-12.6%	33,075	4.1%	-0.2%	-0.3%
7	7	RISPERIDONE	80,998	-1.0%	-2.2%	32,802	4.0%	-0.1%	0.1%
8	10	OLANZAPINE	81,093	1.8%	4.5%	31,150	3.8%	0.0%	0.3%
9	13	METFORMIN HCL	40,833	3.0%	-1.5%	27,595	3.4%	0.0%	0.2%
10	8	FERROUS SULFATE	36,191	0.5%	-11.3%	27,547	3.4%	0.0%	-0.2%
11	9	LORATADINE	38,973	4.8%	-11.7%	27,293	3.3%	0.2%	-0.2%
12	11	DOCUSATE SODIUM	36,317	-4.3%	-10.8%	24,780	3.0%	-0.2%	-0.2%
13	12	AZITHROMYCIN	26,010	32.3%	-12.7%	24,129	3.0%	0.7%	-0.3%
14	15	CEPHALEXIN	23,740	1.0%	-4.3%	22,343	2.7%	-0.1%	0.0%
15	16	LISINOPRIL	32,406	4.3%	-2.2%	22,209	2.7%	0.1%	0.1%
16	17	BENZTROPINE MESYLATE	54,209	-0.8%	-1.8%	21,522	2.6%	-0.1%	0.1%
17	20	ATORVASTATIN CALCIUM	31,276	4.3%	6.5%	21,147	2.6%	0.1%	0.3%
18	14	HYDROCODONE/ACETAMINOPHEN	24,143	-7.0%	-23.6%	19,915	2.4%	-0.3%	-0.6%
19	156	NALOXONE HCL	20,651	252.0%	869.1%	19,577	2.4%	1.7%	2.2%
20	18	ACETAMINOPHEN	18,528	15.5%	-17.4%	17,290	2.1%	0.2%	-0.3%

**Table 6.2: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Medi-Cal FFS Population Only**

Rank	Last Year Rank	Drug Description	Current Quarter 2019 Q1 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	IBUPROFEN	86,531	12.6%	-3.8%	76,668	16.4%	13.0%	-4.1%
2	2	AMOXICILLIN	41,100	27.9%	-11.0%	38,007	8.1%	28.3%	-11.2%
3	3	ALBUTEROL SULFATE	47,396	20.1%	-12.7%	35,224	7.5%	25.4%	-14.3%
4	4	ASPIRIN	46,299	-3.3%	-12.5%	32,561	7.0%	-0.6%	-11.2%
5	5	LORATADINE	38,271	4.3%	-12.1%	26,885	5.8%	10.1%	-10.4%
6	6	FERROUS SULFATE	34,917	0.3%	-9.3%	26,764	5.7%	2.9%	-8.0%
7	8	METFORMIN HCL	38,411	2.1%	-1.4%	26,366	5.6%	4.4%	0.7%
8	7	DOCUSATE SODIUM	35,784	-4.7%	-10.6%	24,381	5.2%	-3.6%	-10.1%
9	12	LISINOPRIL	31,196	3.8%	-1.8%	21,548	4.6%	6.2%	0.5%
10	11	CEPHALEXIN	22,617	1.3%	-3.2%	21,323	4.6%	1.5%	-3.2%
11	15	ATORVASTATIN CALCIUM	30,874	3.1%	7.0%	20,862	4.5%	6.1%	9.3%
12	10	AZITHROMYCIN	22,120	41.2%	-11.7%	20,600	4.4%	43.2%	-11.9%
13	9	HYDROCODONE/ ACETAMINOPHEN	23,760	-7.0%	-22.9%	19,553	4.2%	-6.9%	-23.2%
14	13	PROMETHAZINE/ DEXTROMETHORPHAN	18,957	29.2%	-17.1%	16,971	3.6%	30.6%	-16.6%
15	14	ACETAMINOPHEN	17,730	16.7%	-16.3%	16,547	3.5%	16.3%	-15.3%
16	20	PRENATAL VITAMIN NO 95	16,503	13.1%	108.8%	14,801	3.2%	13.9%	109.7%
17	17	FOLIC ACID	24,094	-1.7%	-6.3%	14,389	3.1%	2.9%	-3.8%
18	18	AMLODIPINE BESYLATE	21,246	2.7%	-0.6%	14,040	3.0%	5.8%	2.8%
19	16	PREDNISONE	16,898	15.6%	-6.2%	13,968	3.0%	18.7%	-6.8%
20	19	GABAPENTIN	22,432	0.4%	-0.9%	13,266	2.8%	2.7%	0.5%

**Table 6.3: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Medi-Cal MCP Population Only**

Rank	Last Year Rank	Drug Description	Current Quarter 2019 Q1 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	QUETIAPINE FUMARATE	127,637	-0.4%	0.3%	49,279	17.3%	1.3%	-0.1%
2	2	ARIPIRAZOLE	94,986	-1.0%	1.1%	41,748	14.6%	0.9%	1.6%
3	3	RISPERIDONE	71,887	-1.4%	-2.0%	29,314	10.3%	0.5%	-2.2%
4	4	OLANZAPINE	72,887	1.3%	4.9%	28,005	9.8%	2.9%	4.2%
5	5	BENZTROPINE MESYLATE	49,659	-1.1%	-1.2%	19,740	6.9%	0.5%	-1.5%
6	13	NALOXONE HCL	18,986	249.4%	863.3%	18,014	6.3%	248.3%	856.7%
7	6	LURASIDONE HCL	38,348	0.5%	3.7%	16,175	5.7%	1.5%	2.6%
8	8	BUPRENORPHINE HCL/ NALOXONE HCL	37,274	4.7%	27.8%	11,270	4.0%	5.9%	24.6%
9	7	LITHIUM CARBONATE	26,566	-1.3%	-3.8%	11,129	3.9%	0.5%	-4.2%
10	9	PALIPERIDONE PALMITATE	18,302	-1.6%	12.6%	7,929	2.8%	2.9%	12.8%
11	10	HALOPERIDOL	16,388	-7.9%	-13.8%	6,504	2.3%	-4.9%	-9.9%
12	11	EMTRICITABINE/ TENOFVIR (TDF)	11,946	-3.2%	-3.0%	6,190	2.2%	-1.0%	1.8%
13	12	ZIPRASIDONE HCL	14,621	-4.4%	-9.6%	5,442	1.9%	-2.7%	-10.0%
14	18	BICTEGRAVIR/EMTRICIT/ TENOFVIR ALA	11,548	20.0%	3276.6%	4,928	1.7%	23.8%	1505.2%
15	14	ELVITEG/COB/EMTRI/ TENOF ALAFEN	9,803	-11.3%	-24.2%	4,174	1.5%	-7.7%	-22.7%
16	15	INSULIN LISPRO	8,823	-5.8%	-5.3%	4,111	1.4%	-6.5%	-5.7%
17	17	INSULIN GLARGINE, HUM.REC.ANLOG	7,268	-4.5%	-14.2%	3,910	1.4%	-5.9%	-13.9%
18	16	EMTRICITABINE/ TENOFVIR ALAFENAM	8,946	-14.5%	-27.8%	3,788	1.3%	-10.4%	-24.0%
19	20	NALTREXONE HCL	6,028	6.6%	28.4%	3,695	1.3%	8.7%	30.2%
20	19	ABACAVIR/DOLUTEGRAVIR/ LAMIVUDINE	8,769	-9.9%	-20.0%	3,672	1.3%	-5.4%	-16.4%

## APPENDIX B: Definition of terms.

**Adjudicate:** To pay or deny drug claims after evaluating the claim for coverage requirements

**Beneficiary:** A person who has been determined eligible for Medi-Cal, as according to the California Code of Regulations 50024

**Eligible beneficiary:** A Medi-Cal beneficiary that qualifies for drug benefits

**Quarter:** One fourth,  $\frac{1}{4}$ , 25% or .25 of a year measured in months.

**Reimbursement:** The reimbursement paid to Medi-Cal pharmacy providers for legend and nonlegend drugs dispensed to Medi-Cal Fee-for-Service (FFS) beneficiaries. Reimbursement is determined in accordance with CA Welfare and Institutions Code Section 14105.45(b)(1).

**Drug therapeutic category:** Drug therapeutic categories are grouping of drugs at various hierarchy levels and characteristics that may be similar in chemical structure, pharmacological effect, clinical use, indications, and/or other characteristics of drug products.

**Utilizing beneficiary:** A Medi-Cal beneficiary with at least one prescription filled during the measurement period



## MEDI-CAL DRUG USE REVIEW (DUR) PROGRAM 2018 BIENNIAL EVALUATION REPORT

### Executive Summary

The purpose of the educational intervention component of DUR is to improve the quality and cost-effectiveness of prescribing and dispensing practices for Medi-Cal beneficiaries. Educational interventions include ongoing dissemination of clinically important information through the Medi-Cal provider bulletin process.

DUR educational articles are published in provider bulletins and posted on the [DUR: Educational Articles](#) page on the DUR website. At least two years after publication, each DUR educational article is reviewed again in a systematic way in order to evaluate any change over time. This biennial evaluation report analyzes each article using the following template:

- Background
- Purpose
- Data Criteria and Findings
- Analysis
- Limitations
- Research/Policy Recommendations
- Clinical Recommendations

Many factors may influence the prescribing and dispensing practices of Medi-Cal providers, making it difficult to accurately measure the full impact of the educational articles. Such factors may include, but are not limited to, the following:

- Changes and updates to treatment guidelines and recommendations
- Beneficiary expectations and requests and healthcare habits and behavior
- Direct-to-consumer advertising
- Provider training and experience
- Anecdotal experience
- Provider resistance

The purpose of DUR educational articles is to apprise Medi-Cal providers and pharmacies of current treatment guidelines and recommendations on drugs, disease states, and medical conditions. These articles contain valuable information that is

effective when used as a part of an overall campaign to disseminate timely and needed information to providers and pharmacies. The following recommendations may help to improve accessibility, reach, and interest of educational articles to the Medi-Cal provider and pharmacy community:

- Continue to distribute articles through normal publication channels, but also send articles separate and independent from the bulletin, in order to increase visibility.
- Distribute article links to medical and pharmaceutical organizations/associations for distribution to their members or publications in journals and/or bulletins.
- Encourage prescribers and pharmacists to sign up for distribution of DUR articles via the Medi-Cal Subscription Service (MCSS).
- Facilitate continuing medical education (CME) and/or continuing education (CE) opportunities to prescribers and pharmacists related to article content
- Incorporate case studies into articles.
- Package articles with other collateral materials for distribution through various media channels such as posters, postcard mailings and flyers that highlight the recommendations of each the article.
- Disseminate shorter educational alerts that highlight relevant and important topics that can be published with greater frequency.
- When appropriate, disseminate lay versions of articles to beneficiaries to promote physician uptake and set beneficiary expectations.
- Continue to support the direct link between articles and retrospective DUR educational outreach to prescribers and pharmacists.
- Increase understanding of prospective DUR alert methodology, by using articles to focus on drug therapy problems that are frequently overridden at the pharmacy level.
- Include patient-specific profiles for educational outreach where the primary objective is an improvement in the quality of care.
- Use provider-specific profiles for educational outreach where the primary objective is an improvement in the quality of prescribing.
- Use pharmacy-specific profiles for educational outreach where the primary objective is an improvement in the quality of dispensing.

The 2018 report provides detailed evaluations of the following DUR educational articles, which were published between October 2014 and September 2016:

- Clinical Review: Use of Nicotine Replacement Therapy for Smoking Cessation – October 2014
- Alert: Folic Acid Awareness Week is January 4th – 10th, 2015 – December 2014
- Alert: Depression Among Perinatal Women is Overlooked and Undertreated – January 2015

- Improving the Quality of Care: Methotrexate Use and Folate Supplementation – February 2015
- Drug Safety Communication: Varenicline and Alcohol Use – March 2015
- Improving the Quality of Care: Antipsychotic Use in Children and Adolescents – March 2015
- Drug Safety Communication: NSAIDs Increase Chance of Heart Attack or Stroke – August 2015
- 2015 Immunization Updates: Influenza, HPV, MenB, PVC13, and SB 277 – September 2015
- Clinical Review: Morphine Equivalent Daily Dose to Prevent Opioid Overuse – September 2015
- Clinical Review: Concomitant Use of Anticholinergics and Antipsychotics – November 2015
- Alert: California Upgrades Prescription Drug Monitoring Program to CURES 2.0 – January 2016
- Drug Safety Communication: Saxagliptin, Alogliptin and Risk of Heart Failure – April 2016
- Clinical Review: Atypical Antipsychotics and Adverse Metabolic Effects – April 2016
- Drug Safety Communication: New Safety Warnings Added to Prescription Opioids – April 2016
- Clinical Review: The Treatment of Opioid Addiction with Buprenorphine – August 2016
- 2016 Immunization Updates: Influenza, Meningococcal, Tdap, Hib, Rotavirus – September 2016

In order to maximize the time the Board will have to review this report, it has been split into two parts. The first eight articles will be presented at the February 2019 meeting (Part I) and the remaining eight articles will be presented at the May 2019 meeting (Part II).

## **Biennial Review: Evaluation of Educational Articles – Part II**

### **9. Clinical Review: Morphine Equivalent Daily Dose to Prevent Opioid Overuse – September 2015**

- **Background:** While there is no completely safe dose of opioids, the use of the morphine equivalent daily dose (MEDD) can be used to indicate potential dose-related risk for prescription drug overdose. While there are differing opinions as to the maximum MEDD threshold that should trigger additional actions by clinicians, the Medical Board of California (MBC) recommends proceeding cautiously once the MEDD reaches 80 mg. Within the Medi-Cal fee-for-service population the vast majority (87%) of paid claims for opioids were well under the 80 mg MEDD threshold recommended by the MBC. However, between July 1, 2014, and June 30, 2015, there were 47,760 paid claims for opioids that exceeded 120 mg MEDD, representing 9% of all paid pharmacy claims for opioids. During this same time period, the majority of Medi-Cal fee-for-service beneficiaries (n = 208,071; 79.4%) had only one paid claim for a prescription opioid medication during this one-year period. However, a total of 3,611 beneficiaries (1.4%) had paid claims for opioids from three or more prescribers and filled these claims at three or more pharmacies.
- **Purpose:** The purpose of this biennial review is to re-evaluate MEDD calculations for all paid pharmacy claims in the Medi-Cal fee-for-service population, in order to determine if there have been any changes in use and prescribing patterns over time. In addition, a review was conducted to assess any updates to the clinical guidelines and selected organizations' MEDD thresholds for additional action since the original article was published.
- **Data Criteria and Findings:** For the biennial review, the same inclusion/exclusion criteria as the published article were followed. The study population included all beneficiaries with at least one pharmacy claim for a prescription opioid medication paid for by the Medi-Cal fee-for-service program between January 1, 2018, and December 31, 2018 (the measurement year).

<b>Medi-Cal fee-for-service population</b>	<b>Article data: 07/01/14 – 06/30/15</b>	<b>Biennial review data: 01/01/18 – 12/31/18</b>	<b>Percent change</b>
<b><i>Beneficiaries identified with at least one pharmacy claim for a prescription opioid medication paid for by the Medi-Cal fee-for-service program during the measurement year.</i></b>	<b>262,017</b>	<b>189,583</b>	<b>-27.6%</b>
Percentage of beneficiaries with only one paid claim for a prescription opioid medication during the measurement year	79.4%	88.4%	9.0%
Percentage of beneficiaries with paid claims for prescription opioid medications from three or more prescribers filled at three or more pharmacies during the measurement year	1.4%	0.7%	-0.7%
<b><i>Percentage of total paid claims for prescription opioid medications paid for by the Medi-Cal fee-for-service program during the measurement year with a days' supply &gt; 14 days.</i></b>	<b>44.8%</b>	<b>35.8%</b>	<b>-9.0%</b>
<b><i>Total paid claims for prescription opioid medications paid for by the Medi-Cal fee-for-service program during the measurement year with a days' supply &gt; 14 days.</i></b>	<b>237,106</b>	<b>174,569</b>	<b>-26.4%</b>
Percentage of paid pharmacy claims > 14 days supply exceeding 80 mg MEDD	26.4%	4.6%	-21.8%
Percentage of paid pharmacy claims > 14 days supply exceeding 100 mg MEDD	22.8%	3.3%	-19.5%
Percentage of paid pharmacy claims > 14 days supply exceeding 120 mg MEDD	18.5%	2.6%	-15.9%

- **Analysis:** The MEDD threshold for almost every organization listed in the original article has decreased since the original article was published. This is primarily due to the [CDC Guideline for Prescribing Opioids for Chronic Pain](#), which were released in 2016, shortly after publication of the original article. There have also been legislative and policy changes at both the state and federal level that have expanded access to medication-assisted treatments for opioid use disorder and added additional requirements to providers who prescribe opioids, including mandatory consultation of prescription monitoring program data and

offering a prescription for naloxone (or similar drug) for patients at higher risk of opioid-induced respiratory depression.

Within the Medi-Cal fee-for-service program, the MEDD data calculated from paid pharmacy claims show significant changes since the original article was published. There was a 27.6% decrease in beneficiaries identified with at least one pharmacy claim for a prescription opioid medication paid for by the Medi-Cal fee-for-service program during the measurement year. The percentage of these beneficiaries with only one paid claim for a prescription opioid medication increased by 9.0%, and the percentage of these beneficiaries with paid claims for prescription opioid medications from three or more prescribers filled at three or more pharmacies during the measurement year decreased from 1.4% to 0.7%. In addition, the percentage of total paid claims for prescription opioid medications paid for by the Medi-Cal fee-for-service program during the measurement year with a days' supply > 14 days decreased from 44.8% to 35.8%, showing providers are prescribing opioids for shorter durations. Of the paid claims for prescription opioid medications > 14 days' supply, the percentage that exceeded 80 mg MEDD also decreased, from 26.4% to 4.6%.

Overall, there are fewer beneficiaries overall with paid claims for opioids, fewer beneficiaries with more than one paid claim for opioids, fewer beneficiaries with paid claims from multiple prescribers and pharmacies, fewer beneficiaries receiving > 14 days' supply of opioids, and fewer beneficiaries with paid claims for opioids that exceed the 80 mg MEDD recommended by the MBC.

- **Limitations:** Since the original article was published, the CDC has updated their [Calculating Total Daily Dose of Opioids for Safer Dosage](#) factsheet to include the following footnote in the section on how to use calculated morphine milligram equivalents (MMEs): "These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder." Further, in their conversion file, the CDC removed MMEs for buprenorphine and included the statement "Buprenorphine products are listed in this file but do not have an associated MME conversion factor. The conversion factors for drugs prescribed or provided as part of medication-assisted treatment for opioid use disorder should not be used to benchmark against dosage thresholds meant for opioids prescribed for pain. These buprenorphine products, as partial opioid agonists, are not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids." When the original article was published, buprenorphine products prescribed for opioid use disorder were included in the

MEDD calculations and are incorporated in the results. The updated data do not include paid claims for buprenorphine products prescribed for opioid use disorder, per the updated CDC recommendations.

Finally, the original DUR article was intended to be a general overview of MEDD in the Medi-Cal fee-for-service population, and the same is true for this biennial review. Further limitations of these data also include the following: 1) these data are based only on total paid claims and days' supply instead of by quantity dispensed; and 2) while prescribers at the same practice location address were counted as one prescriber, practice location data remains subject to inaccuracy, and no attempts were made to confirm practice location data in either the original article or in this biennial review. It should be noted that the accuracy of practice location data has improved slightly since the original article was published, due to targeted efforts by Medi-Cal to improve provider enrollment data.

- **Research/Policy Recommendations:**

1. Continue to monitor the use of opioids and MEDD within the Medi-Cal fee-for-service population.
2. Continue to assess the need for additional policy restrictions on opioids, including restrictions on MEDD, maximum quantities, beneficiary age, and duration of treatment allowed.
3. Continue to review federal and state policy guidelines and restrictions on use of opioids and MEDD.
4. Continue to collaborate with state agencies like the Board of Pharmacy and the Medical Board of California to combat prescription drug abuse and diversion.
5. Continue to develop targeted DUR educational outreach to providers and pharmacies, as needed, to promote responsible prescribing of opioids.
6. Continue to educate providers on MEDD and share any helpful resources for the calculation MEDD in clinical practice locations.

- **Clinical Recommendations:**

1. Follow the [CDC Guideline for Prescribing Opioids for Chronic Pain](#).
2. Review the [Guideline Resources](#) available on the CDC website, which include clinical tools and materials for patients.
3. Review materials and resources for preventing prescription drug abuse that are available through the California State Board of Pharmacy, Medical Board of California, and the California Department of Public Health.

4. Offer a prescription for naloxone or another drug approved by the FDA for the complete or partial reversal of opioid-induced respiratory depression.
5. If opioid use disorder is suspected, health care providers should discuss their concerns with their patients and provide an opportunity for the patient to disclose related concerns or problems.
6. For patients meeting criteria for opioid use disorder, health care providers should offer or arrange for patients to receive evidence-based treatment, including medication-assisted treatment (MAT) with buprenorphine in combination with behavioral therapies.

## 10. Clinical Review: Concomitant Use of Anticholinergics and Antipsychotics – November 2015

- Background:** Anticholinergic medications including benztropine and trihexyphenidyl are often prescribed to prevent or treat antipsychotic-induced extrapyramidal symptoms (EPS), including tremor, rigidity, bradykinesia, and acute dystonia. However, the need for continued therapy with anticholinergics is frequently not reassessed and many patients remain on them for several years, or even decades, despite association with cognitive impairment and worsening of tardive dyskinesia, especially among persons 65 years of age and older. Prescribers may be reluctant to discontinue anticholinergics even when patients are prescribed second-generation antipsychotics, which are less likely than first-generation antipsychotics to induce EPS. The consensus among the medical community is that prophylaxis of EPS with anticholinergics is generally not indicated in patients receiving antipsychotics and that anticholinergic use should be limited to when parkinsonism arises and when other measures, such as dose reduction, have failed. Among Medi-Cal beneficiaries with a paid claim for an anticholinergic medication greater than or equal to 30 days supply, almost all beneficiaries (96%) also had at least one paid claim for an antipsychotic medication during the same time period.
- Purpose:** The purpose of this biennial review is to re-evaluate the concomitant use of anticholinergic and antipsychotic medications in the Medi-Cal fee-for-service population, in order to determine if there have been any changes in use and prescribing patterns over time. In addition, a review was conducted to assess any updates to clinical guidelines regarding the use of anticholinergics since the original article was published.
- Data Criteria and Findings:** For the biennial review, the same inclusion/exclusion criteria as the published article were followed. All paid pharmacy claims for benztropine and trihexyphenidyl were reviewed with dates of service between January 1, 2018 and December 31, 2018 (the measurement year). Beneficiaries were then evaluated for concomitant use of antipsychotic medications during the same measurement year. Data were then stratified by concomitant use of first- or second-generation antipsychotics.

Medi-Cal population	Article data: 09/01/14 – 08/31/15	Biennial review data: 01/01/18 – 12/31/18	Percent change
<i>Beneficiaries identified with a paid claim for benztropine and/or trihexyphenidyl with ≥ 30 days' supply during the measurement year</i>	34,879	34,792	<b>-0.2%</b>
Percentage with ≥ 6 paid claims for anticholinergics during the measurement year	50.9%	53.2%	<b>2.3%</b>
Percentage with ≥ 12 paid claims for anticholinergics during the measurement year	17.3%	25.4%	<b>8.1%</b>
Percentage ≥ 65 years of age	1.0%	1.7%	<b>0.7%</b>
Percentage with ≥ 1 paid claim for an antipsychotic medication during the measurement year	96.3%	97.9%	<b>1.6%</b>

In June 2016, a DUR educational outreach letter to physicians prescribing concomitant anticholinergic and antipsychotic medications to Medi-Cal fee-for-service beneficiaries ≥ 65 years of age was completed. The 12% provider response rate for this mailing remains the lowest response rate of any DUR educational outreach letter to providers to date. However, there was a slight decrease in the concomitant use of anticholinergic medications and atypical antipsychotics among the Medi-Cal fee-for-service beneficiaries with providers who received the mailing. While acknowledging that only a very small sample of providers returned the patient survey, the majority of the comments received suggest that these medications may be legacy medications from another physician, and the patients or their caregivers may be reluctant to make a change.

- **Analysis:** Overall, the number of beneficiaries identified with a paid claim for benztropine and/or trihexyphenidyl with ≥ 30 days' supply during the measurement year decreased slightly (< 1%) since the original article was published. However, there are some areas for potential improvement, as a higher percentage of beneficiaries taking anticholinergic medications appeared to be taking anticholinergic medications chronically (greater than 6 paid claims), and almost double the study population was ≥ 65 years of age (increased from 1.0%

to 1.7%). There have been no updated clinical guidelines regarding concomitant use of anticholinergic and antipsychotic medications since the original article was published.

- **Limitations:** Without access to detailed clinical information, it is difficult to determine whether beneficiaries are being prescribed anticholinergic medications prophylactically, as treatment for EPS related to concomitant use of antipsychotic medications, or for another reason.
- **Research/Policy Recommendations:**
  1. Update the original DUR educational article to include EPS propensity for asenapine, iloperidone, and lurasidone.
  2. Continue to monitor clinical guidelines for updates and changes in standards of medical care regarding concomitant use of anticholinergic and antipsychotic medications.
  3. Continue to monitor anticholinergic utilization using Medi-Cal pharmacy claims data.
  4. Consider collaboration with Medi-Cal managed care plans (MCPs) to evaluate use of anticholinergic medications among MCP enrollees at increased risk of cognitive decline and dementia.
- **Clinical Recommendations:**
  1. For patients taking first-generation antipsychotics, prophylactic use of anticholinergic medications to prevent extrapyramidal symptoms should be determined on a case-by-case basis. Patient-specific and medication-specific factors should be considered.
  2. For patients taking second-generation antipsychotics, prophylactic anticholinergic medications are not recommended.
  3. Continued use of anticholinergic medications should be re-evaluated in patients with controlled symptoms every three months.
  4. Older patients and/or persons with high genetic risk of cognitive disorder who use anticholinergic medications are at increased risk of cognitive decline and dementia. Providers should consider discontinuation of anticholinergic medications in these populations.

# 11.Alert: California Upgrades Prescription Drug Monitoring Program to CURES 2.0 – January 2016

- **Background:** Effective January 8, 2016, California updated their prescription drug monitoring program, the Controlled Substance Utilization Review and Evaluation System (CURES) to CURES 2.0. The upgraded database offered an improved user experience and added functionalities, including the ability to delegate report queries and new practitioner-identified patient alerts. In addition, a streamlined registration process was implemented for new users. Licensed health care prescribers and pharmacists were now able to request access to the CURES database and validate their credentials entirely online using a secure web browser.
- **Purpose:** The purpose of this biennial review is to review if there were any updates with regards to CURES 2.0 since the original DUR alert was published in January 2016.
- **Data Criteria and Findings:** Pursuant to Section 11165.4(e) of the Health and Safety Code, the State of California Department of Justice (DOJ) certified the CURES 2.0 database for statewide use on April 2, 2018. Effective for dates of service on or after October 2, 2018, it is mandatory to consult the CURES 2.0 database prior to prescribing, ordering, administering, or furnishing a Schedule II – IV controlled substance. Mandatory consultation applies to any health care provider with both (1) a Drug Enforcement Administration Controlled Substance Registration Certificate and (2) a California licensure as any one of the following:
  - Dentist
  - Physician
  - Naturopathic Doctor
  - Optometrist
  - Osteopathic Doctor
  - Physician Assistant
  - Podiatrist
  - Registered Certified Nurse Midwife (Furnishing)
  - Registered Nurse Practitioner (Furnishing)

These health care providers are required to consult the CURES 2.0 database to review a patient's controlled substance history before prescribing a Schedule II – IV controlled substance to the patient for the first time and at least once every

four months thereafter if the substance remains part of the treatment of the patient.

Of note, the mandatory consultation requirement does not apply to either veterinarians or pharmacists. However, each pharmacist filling a prescription has a corresponding responsibility to ensure the prescription is legal and not for purposes of abuse.

The CURES 2.0 system provides alerts to clinicians when their patient's aggregate prescription level exceeds certain thresholds. Alerts are presented at the following therapy thresholds:

1. Patient is currently prescribed more than 90 morphine milligram equivalents per day
  2. Patient has obtained prescriptions from 6 or more prescribers or 6 or more pharmacies during last 6 months
  3. Patient is currently prescribed more than 40 morphine milligram equivalents of methadone daily
  4. Patient is currently prescribed opioids more than 90 consecutive days
  5. Patient is currently prescribed both benzodiazepines and opioids
- **Analysis:** The DOJ now provides publicly available [aggregate data](#) of the dispensation information reported and – over time – they plan to render portions of these data into easily readable charts, graphs, and maps.
  - **Limitations:** None.
  - **Research/Policy Recommendations:**
    1. Monitor DOJ releases of aggregate data for research opportunities.
    2. Continue to follow legislation related to CURES 2.0 and convey updates to providers.
    3. Research is needed to determine optimal approaches to interpreting CURES profiles in relation to clinical judgment, patient screeners, and other information.
  - **Clinical Recommendations:**
    1. Clinical practice guidelines encourage use of a prescription drug monitoring program (PDMP) prior to prescribing to assess a patient's history of controlled substance use.

2. In order to improve patient safety, health care providers should not dismiss patients from care based on data obtained from the PDMP. The CDC recommends the following actions instead:
  - If patients are receiving high total opioid dosages consider collaborating with the patient to taper to a safer dosage and offering naloxone.
  - If patients are taking benzodiazepines with opioids communicate with others managing the patient and weigh patient goals, needs, and risks.
  - If considering a diagnosis of opioid use disorder, discuss safety concerns and treatment options with patients.

## 12. Drug Safety Communication: Saxagliptin, Alogliptin and Risk of Heart Failure – April 2016

- **Background:** Saxagliptin and alogliptin are part of the class of prescription medicines called dipeptidyl peptidase-4 (DPP-4) inhibitors, which are used with diet and exercise to control high blood sugar in adults with type 2 diabetes. A U.S. Food and Drug Administration (FDA) safety review found that medicines containing saxagliptin and alogliptin may increase the risk of heart failure, particularly in patients who already have heart or kidney disease. On April 5, 2016, the FDA announced they added new information to the Warnings and Precautions sections for labels of medications containing saxagliptin or alogliptin to inform patients of the potential increased risk of heart failure.
- **Purpose:** The purpose of this biennial review is to review the FDA safety communications on DPP-4 inhibitors since the publication of the original article and to describe any relevant updates to this class of drugs.
- **Data Criteria and Findings:** In September 2017, the FDA required label updates regarding the risk of developing heart failure in patients with cardiovascular disease to all DPP-4 inhibitors, including sitagliptin and linagliptin. The Warnings and Precautions section for labels of medications containing sitagliptin and linagliptin now state that heart failure has been observed with two other members of the DPP-4 inhibitor class. The labels also caution providers to consider risks and benefits in patients who have known risk factors for heart failure and to monitor patients for signs and symptoms.
- **Analysis:** To date, no direct studies have linked either sitagliptin or linagliptin with increasing risk of cardiovascular events, including heart failure. The FDA seems to be taking a conservative approach based on other studies of DPP-4 inhibitors.
- **Limitations:** None.
- **Research/Policy Recommendations:**
  1. Continue to monitor research and FDA communications regarding DPP-4 inhibitors.
  2. Evaluate the use of DPP-4 inhibitors among the Medi-Cal population, including by those patients with heart disease or risk factors for developing heart disease.

- **Clinical Recommendations:**

1. Consider the risks and benefits of DPP-4 inhibitors in patients with known risk factors for heart failure.
2. Monitor patients taking DPP-4 inhibitors for signs and symptoms of heart failure, such as unusual shortness of breath during daily activities, trouble breathing when lying down, tiredness, weakness, or fatigue, and/or weight gain with swelling in the ankles, feet, legs, or stomach.
3. Consider discontinuing the use of DPP-4 inhibitors in patients who develop heart failure.

### 13. Clinical Review: Atypical Antipsychotics and Adverse Metabolic Effects – April 2016

- **Background:** Antipsychotic medications are an important component in the medical management of a variety of psychiatric disorders and severe behavioral disturbances. Since the introduction of atypical antipsychotics, or second-generation antipsychotics, the use of these medications has soared for both on-label and off-label uses. Although the atypical antipsychotics have many notable benefits compared with their earlier counterparts, their use has been associated with potentially serious adverse metabolic effects, including weight gain, hyperlipidemia, and glucose intolerance. Modifiable risk factors for cardiovascular disease are common in patients with major mental illness and should be addressed even in the absence of metabolic changes. Consensus guidelines for screening and monitoring of adverse metabolic effects should be used to guide patient management.

In a review of Medi-Cal fee-for-service beneficiaries with at least two years of continuous atypical antipsychotic use, approximately one-third of beneficiaries in did not have an FDA-approved indication documented in their medical claims. Higher rates of FDA-approved indications were seen among those beneficiaries taking clozapine (87%) or two or more atypical antipsychotics concurrently (78%). The majority of beneficiaries (67%) had at least one co-morbid metabolic condition, with the most common comorbidity being hypertension (42%). A total of 4,507 beneficiaries (69%) had both recommended monitoring tests (blood glucose or HbA1c and LDL-C or cholesterol) completed within the past two years. The rates were much higher for blood glucose or HbA1c (84%) when compared to LDL-C or cholesterol (69%). Importantly, monitoring rates were greater among those beneficiaries with a co-morbid metabolic condition and among those taking concomitant statins, ACE inhibitors/ARBs and/or metformin.

- **Purpose:** The purpose of this biennial review is to review any updates to the clinical guidelines for therapeutic monitoring of patients starting and continuing on atypical antipsychotics and to evaluate the rates of metabolic monitoring among the Medi-Cal fee-for-service population taking atypical antipsychotic medications, in order to determine if there have been any changes over time.
- **Data Criteria and Findings:** For the biennial review, the same methodology and inclusion/exclusion criteria as the published article were followed:
  1. Inclusion criteria:
    - i. Continuous eligibility for the Medi-Cal FFS program between November 1, 2016, and February 28, 2019.

- ii. Between 18 and 64 years of age throughout the duration of the measurement year (between March 1, 2018, and February 28, 2019).
- iii. At least one paid claim for an atypical antipsychotic medication during every four-month period between November 1, 2016, and February 29, 2019.

Beneficiaries were classified as being on two or more atypical antipsychotics if there was an overlap of two or more atypical antipsychotic medications for greater than 90 consecutive days during the measurement year. Medical claims were reviewed for any documented FDA-approved indication for each atypical antipsychotic. Metabolic monitoring rates were calculated by reviewing medical claims data from the same timeframe as the initial inclusion criteria (November 1, 2016, through February 28, 2019). This expanded timeframe was used to capture any metabolic monitoring within at least a two-year period (two months were added on either end of the 2017 – 2018 calendar years to allow an additional window).

<b>Medi-Cal fee-for-service population</b>	<b>Article data: 11/01/13 – 02/29/16</b>	<b>Biennial review data: 11/01/16 – 02/28/19</b>	<b>Percent change</b>
<b><i>Beneficiaries identified with at least two years of continuous atypical antipsychotic use.</i></b>	<b>6,561</b>	<b>3,616</b>	<b>-44.9%</b>
Percentage with an FDA-approved indication documented in their medical claims.	64.6%	67.1%	2.5%
Percentage with concurrent paid claims for two or more atypical antipsychotic medications for at least 90 consecutive days.	20.6%	28.8%	8.2%
Percentage with a metabolic-related comorbidity.	67.0%	70.2%	3.2%
Percentage with both monitoring tests (blood glucose or HbA1c and LDL-C or cholesterol) completed within the past two years.	68.7%	77.9%	9.2%
Percentage with a blood glucose or HbA1c monitoring test completed within the past two years.	84.2%	89.8%	5.6%
Percentage with an LDL-C or cholesterol monitoring test completed within the past two years.	69.1%	78.2%	9.1%

- **Analysis:** While there has been a decrease in the total number of utilizing beneficiaries with a paid claim for antipsychotics in the Medi-Cal fee-for-service program, there has been an 8% increase in the number of utilizing beneficiaries with concurrent paid claims for two or more atypical antipsychotic medications for at least 90 consecutive days since the original DUR article was published. In addition, the percentage of beneficiaries taking antipsychotic medications that have a metabolic-related comorbidity also increased by 3% since the original article. However, monitoring rates for both monitoring tests (blood glucose or HbA1c and LDL-C or cholesterol) increased over time as well.

Lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health and economic outcomes. The 2019 Adult Core Set Measure entitled, “Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)” is used to assess the percentage of members 18 to 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test. This is one of the measures that have been proposed by the DUR program for evaluation and subsequent educational interventions, if indicated.

- **Limitations:** Clinical data are not available in the pharmacy and medical administrative claims databases, including results of metabolic screening.
- **Research/Policy Recommendations:**
  1. Health care providers should make sure that appropriate monitoring tests, including a fasting glucose test and full lipid profile are completed prior to initiation of antipsychotic therapy and at regular intervals thereafter, as needed.
  2. Continue to discuss opportunities for further evaluation of antipsychotic use in the Medi-Cal population.
  3. Continue to evaluate performance measures related to metabolic monitoring using pharmacy and medical claims data from the Medi-Cal fee-for-service population.
  4. Discuss whether additional educational outreach to providers should be developed to target top prescribers of antipsychotic polypharmacy to beneficiaries.

5. Discuss whether antipsychotic medications, especially antipsychotic polypharmacy, should be subjected to any additional restrictions on the Medi-Cal List of Contract Drugs.

- **Clinical Recommendations:**

1. Prescribe atypical antipsychotics for FDA-approved indications and address modifiable risk factors (smoking, obesity, lack of physical activity, unhealthy diet) in patients with mental illness even in the absence of metabolic changes.
2. When prescribing a new antipsychotic medication or when making adjustments to an existing regimen, educate patients about the anticipated benefits and possible problems associated with the drug and the importance and purpose of laboratory monitoring.
3. Follow ADA and APA consensus guidelines for baseline assessment and monitoring, including measuring waist circumference three and six months after starting treatment and annually thereafter.
4. For patients with a worsening metabolic profile, especially weight gain, consider switching from an agent with a high risk of metabolic side effects to an agent with low risk.
5. Primary care and mental health providers should communicate frequently for early detection of adverse metabolic effects and to minimize duplicate laboratory monitoring/workup.

#### 14. Drug Safety Communication: New Safety Warnings Added to Prescription Opioids – April 2016

- **Background:** Opioids are a class of prescription medicines used to manage pain when other treatments and medicines cannot be taken or are not able to provide enough pain relief. Opioids have serious risks, including abuse, addiction, overdose, and death. On March 22, 2016, the United States Food and Drug Administration (FDA) announced several safety issues with the entire class of prescription opioid medications and are requiring changes to opioid labels to warn about the following:
  1. Opioids can interact with antidepressants and migraine medicines to cause serotonin syndrome, in which high levels of the chemical serotonin build up in the brain and cause toxicity.
  2. Taking opioids may lead to a rare but serious condition called adrenal insufficiency in which the adrenal glands do not produce adequate amounts of the hormone cortisol.
  3. Long-term use of opioids may be associated with decreased sex hormone levels and symptoms such as reduced interest in sex, impotence, or infertility.
- **Purpose:** The purpose of this biennial review is to review the FDA safety communications on opioid medications since the publication of the original article and to describe any relevant updates to this class of drugs.
- **Data Criteria and Findings:** There have been multiple FDA communications related to opioids since this drug safety communication on March 22, 2016. The FDA has developed the [Timeline of Selected FDA Activities and Significant Events Addressing Opioid Misuse and Abuse](#), which is available on the Drug Safety and Availability Web page of the FDA website. The following communications were shared with Medi-Cal providers through DUR educational bulletins and alerts since the original article was published in June 2016:
  1. On August 31, 2016, the FDA announced that it would require class-wide changes to drug labeling to help inform health care providers and patients of the serious risks associated with the use of certain opioid medications in combination with benzodiazepines and other CNS depressants. The new *Boxed Warnings* are the result of an FDA review that found serious side effects, including slowed or difficult breathing and death attributed to co-prescribing of opioids with CNS depressants, including benzodiazepines, non-benzodiazepine receptor agonists, and antipsychotics.

2. On April 20, 2017, the FDA announced it is restricting the use of codeine and tramadol medicines in children. They are also recommending against the use of codeine and tramadol medicines in breastfeeding mothers due to possible harm to their infants.
3. On January 11, 2018, the FDA announced it is requiring safety labeling changes for prescription cough and cold medicines containing codeine or hydrocodone to limit the use of these products to adults 18 years of age and older because the risks of these medicines outweigh their benefits in children younger than 18 years of age. The FDA is also requiring the addition of safety information about the risks of misuse, abuse, addiction, overdose, death, and slowed or difficult breathing to the *Boxed Warning* on drug labels for prescription cough and cold medicines containing codeine or hydrocodone.
4. On April 9, 2019, the FDA issued a warning that it received reports of serious harm in patients who are physically dependent on opioid pain medicines when these medicines are suddenly discontinued or the dose is rapidly decreased. Examples of serious harm include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide. The FDA is requiring expanded guidance within the prescribing information of opioids that are intended for use in the outpatient setting on how to safely decrease the dose in patients who are physically dependent on opioids

In addition to FDA actions, there have been significant federal and state legislative actions taken to combat the opioid epidemic. In 2016, California updated their prescription drug monitoring program, the Controlled Substance Utilization Review and Evaluation System (CURES), to CURES 2.0. Pursuant to Section 11165.4(e) of the Health and Safety Code, this upgraded database was certified for statewide use by the Department of Justice on April 2, 2018. Effective for dates of service on or after October 2, 2018, it is mandatory to consult the CURES 2.0 database prior to prescribing, ordering, administering, or furnishing a Schedule II – IV controlled substance.

Finally, on October 24, 2018, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act was signed into law. This legislation contains a number of provisions related to Medicaid's role in helping states provide coverage and services to people who need substance use disorder (SUD) treatment, particularly those needing opioid use disorder (OUD) treatment. The SUPPORT Act requires state Medicaid programs to have drug utilization review safety edits for opioid refills and an automated claims review process to identify refills in

excess of state limits, monitor concurrent prescribing of opioids and benzodiazepines or antipsychotics, and require managed care plans to have these processes in place as of 10/1/19. The SUPPORT Act also requires state Medicaid programs to cover all FDA-approved medication-assisted treatment (MAT) drugs, from 10/1/20-9/30/25, including methadone, licensed biological products to treat opioid use disorder, and counseling services and behavioral therapy.

- **Analysis:** The biennial review shows the FDA is closely monitoring opioid utilization across all age groups and issuing warnings and safety labeling changes for areas of concern. Recent opportunities for collaboration with other state agencies through the Statewide Opioid Safety Workgroup could maximize the impact of DUR educational bulletins and allow the DUR program to provide an additional forum for cohesive, consistent messaging to providers and dissemination of work products. The DUR program is also awaiting guidance regarding the final requirements of the SUPPORT Act and will play a central role in the implementation of this legislation.
- **Limitations:** None.
- **Research/Policy Recommendations:**
  1. Continue to monitor the use of opioids and other controlled medications in the Medi-Cal population.
  2. Continue to work with other state agencies in order to deliver unified messaging to providers and to allow for the integration of statewide priorities into DUR interventions.
  3. Continue to assess the need for additional policy restrictions on opioids, including maximum quantity and duration restrictions and recent age restrictions.
  4. Continue to assess the impact of federal and state policy legislation on use of opioids and other controlled medications.
  5. Continue to collaborate with state agencies like the Board of Pharmacy and the Audits & Investigations Branch to combat prescription drug abuse and diversion.
  6. Continue to develop targeted DUR educational outreach to providers and pharmacies, as needed, to promote responsible prescribing of controlled substances.

- **Clinical Recommendations:**

1. Health care providers should discontinue opioid treatment and/or use of the other medicine if serotonin syndrome is suspected.
2. Health care providers should perform diagnostic testing if adrenal insufficiency is suspected. If diagnosed, treat with corticosteroids and wean the patient off of the opioid if appropriate. If the opioid can be discontinued, a follow-up assessment of adrenal function should be performed to determine if treatment with corticosteroids could be discontinued.
3. Health care providers should conduct laboratory evaluations in patients taking opioids that present with such signs or symptoms of low libido, impotence, erectile dysfunction, lack of menstruation, or infertility.
4. Health care professionals should limit prescribing opioid pain medications with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate.
5. Health care providers should be aware that tramadol and single-ingredient codeine medicines are FDA-approved only for use in adults. Over-the-counter (OTC) or other FDA-approved prescription medicines should be considered for pain management in children younger than 12 years of age and in adolescents younger than 18 years of age, especially those with certain genetic factors, obesity, or obstructive sleep apnea and other breathing problems.
6. Health care providers should be aware that the FDA changed the age range for which prescription opioid cough and cold medicines are indicated. These products will no longer be indicated for use in children, and their use in this age group is not recommended.
7. Health care providers should reassure parents that cough due to a cold or upper respiratory infection in children is self-limited and prescription opioid cough and cold medicines are not a recommended treatment.
8. Health care providers are required to consult the CURES 2.0 database to review a patient's controlled substance history before prescribing a Schedule II – IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.
9. Health care providers should not abruptly discontinue opioids in a patient who is physically dependent on opioids.

## 15. Clinical Review: The Treatment of Opioid Addiction with Buprenorphine – August 2016

- **Background:** Buprenorphine-containing products are an effective first-line treatment for opioid addiction. As a result, policymakers at both the federal and state level are working to expand access to buprenorphine-containing products including the following two recent changes:
  1. As of June 1, 2015, an approved *Treatment Authorization Request* (TAR) is no longer required by Medi-Cal for buprenorphine-containing products when prescribed by qualified physicians for the treatment of individuals with opioid addiction.
  2. As of August 8, 2016, federal regulations now allow qualified providers to treat up to 275 patients with buprenorphine-containing products for opioid addiction. These regulations also allow nurse practitioners (NPs) and physician assistants (PAs) who have completed the 24 hours of required training to obtain a DATA 2000 waiver for up to 30 patients.

A review of claims data in the Medi-Cal fee-for-service population over a one-year time period (the year following the removal of the TAR restriction) showed 47% of beneficiaries are adherent to the buprenorphine treatment regimen and have extremely low concomitant use of any opioid during the same time period (3% concomitant use overall, and 2% use in the adherent group). In the Medi-Cal fee-for-service population adherent group, the average number of buprenorphine claims per beneficiary during the measurement year was  $13.5 \pm 6.5$  (mean  $\pm$  standard deviation) claims.

- **Purpose:** The purpose of this biennial review is to re-evaluate the use of buprenorphine in the Medi-Cal population, in order to determine if there have been any changes in use and prescribing patterns over time. In addition, a review was conducted to assess any updates to clinical guidelines or legislative efforts for medication-assisted treatment since the original article was published.
- **Data Criteria and Findings:** For the biennial review, the same methodology for calculating the medication possession ratio (MPR) and the same inclusion/exclusion criteria as the published article were followed:
  1. Inclusion criteria:
    - i. Continuous eligibility for the Medi-Cal FFS program between January 1, 2018 and December 31, 2018 (the measurement year).
    - ii. At least one paid claim for buprenorphine or buprenorphine/naloxone during the measurement year.

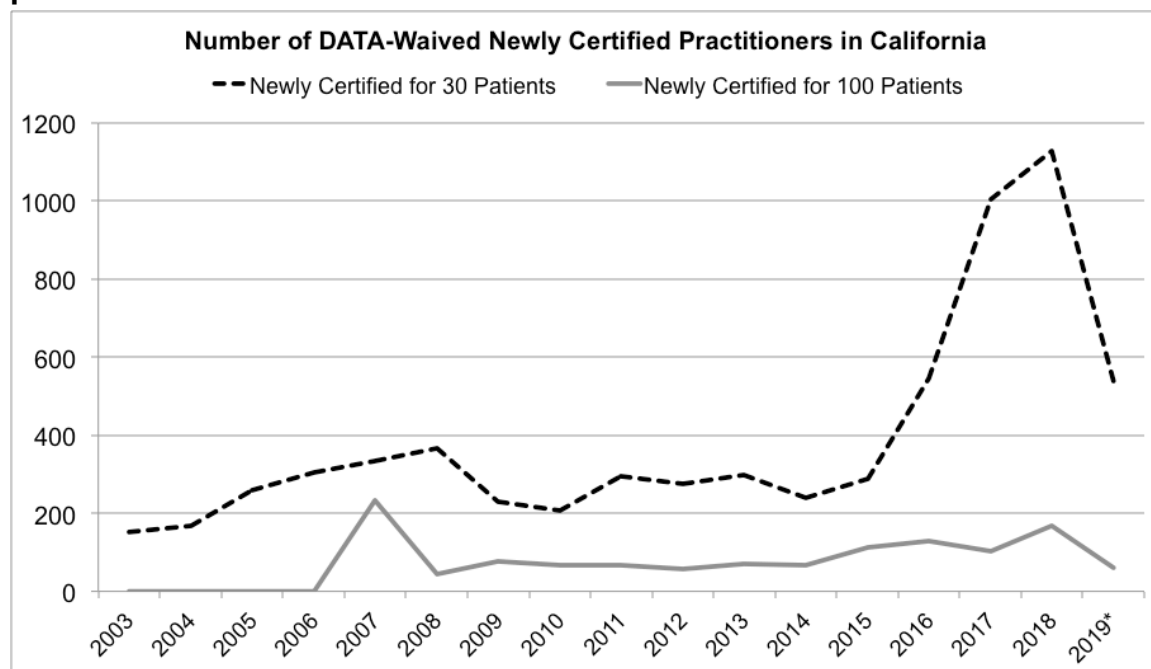
Medi-Cal fee-for-service population	Article data: 06/01/15 – 05/31/16	Biennial review data: 01/01/18 – 12/31/18	Percent change
<b><i>Beneficiaries identified with at least one paid claim for either buprenorphine or buprenorphine/naloxone.</i></b>	<b>5,657</b>	<b>278</b>	<b>-95.1%</b>
Percentage with a buprenorphine adherence rate between 80% and 120% during the measurement year.	47.3%	51.8%	<b>4.5%</b>
Percentage with at least one paid claim for any other opioid medication, during the measurement year.	2.7%	0.8%	<b>-1.9%</b>
<b><i>Beneficiaries identified with only one paid claim for either buprenorphine or buprenorphine/naloxone.</i></b>	<b>656</b>	<b>112</b>	<b>-82.9%</b>
Percentage with at least one paid claim for any other opioid medication, during the measurement year.	5.5%	9.8%	<b>4.3%</b>

- **Analysis:** There has been a significant decrease (a decrease of 95%) in the total number of continuously eligible Medi-Cal fee-for-service beneficiaries that have a paid claim for at least one paid claim for either buprenorphine or buprenorphine/naloxone. The rate of decrease is greater than the rate of migration out of the FFS program and so an evaluation was conducted to review why this number was so low. The number of overall FFS beneficiaries with a paid claim for buprenorphine during this time period was actually much closer to the 5,657 utilizing beneficiaries observed in the original article (n = 4,212), although almost all of these patients did not meet the 12 months of continuous eligibility required in the inclusion criteria in the original article. A common pattern observed was for beneficiaries to newly enroll into the Medi-Cal program and receive one paid claim for buprenorphine through the FFS program before transitioning into a Medi-Cal MCP to continue their treatment. Research to evaluate adherence to buprenorphine treatment in the MCP population may be helpful as a future topic of interest.

There has been one addition to the buprenorphine formulations available through the Medi-Cal Program since the original article was published: a buprenorphine/naloxone sublingual tablet is now available in 11.4 mg/2.9 mg strength. Since the original article was published, there have been no updates to clinical guidelines regarding use of buprenorphine to treat substance use disorder from either the Substance Abuse and Mental Health Services Administration (SAMSHA) or the American Society of Addiction Medicine.

Federal legislation expanding the number of patients who can be treated under DATA 2000 waivers has increased the volume of newly certified practitioners over time, as shown in in **Figure 1**, below.

**Figure 1. New DATA Waivers for California Health Practitioners, 2003-present.**



\*As of April 26, 2019

As shown in **Figure 1**, the greatest increase in newly certified providers in California occurred right after the 2016 allowing nurse practitioners (NPs) and physician assistants (PAs) who have completed the 24 hours of required training to obtain a DATA 2000 waiver for up to 30 patients. Data shown are current through April 26, 2019, and if the rate in new certifications continues through the end of the year, the number of providers newly certified in 2019 will be the most to-date.

Finally, there have been two DUR educational outreach letters to providers related to buprenorphine since the original article was published. The first mailing went out on November 11, 2016. The top 100 prescribers of opioids (by volume) without a current buprenorphine waiver were sent a letter with more information about buprenorphine training. In addition, a total of 100 top prescribers (by total number of patients) of buprenorphine in the Medi-Cal program were sent a letter thanking them for obtaining the waiver and letting

them know that the maximum number of patients that qualified providers can treat has been raised to 275. Each mailing also included the Medi-Cal DUR article on buprenorphine and a provider response survey. Within 12 months, five of the providers without a waiver had completed the training and quantity of opioids prescribed by these providers decreased by 30%. In May 2018, the DUR Board recommended a repeat of the mailing. On August 23, 2018, a total of 100 letters were mailed to top prescribers of opioids (by billed quantity) across all Medi-Cal (included both FFS and MCP paid pharmacy claims) without a waiver to provide buprenorphine treatment. Final outcomes of this mailing will be evaluated and presented at the November 2019 Board meeting.

- **Limitations:** The original article did not exclude beneficiaries with paid claims for formulations of buprenorphine indicated for pain management. For the biennial review, the analysis was completed both with these beneficiaries included and without these beneficiaries included. When it was determined that this cohort represented less than 10 eligible beneficiaries, they were excluded from the updated analysis as their inclusion or exclusion did not have an impact on the results. Data for the parameters included in the original article was also rerun and it was found these beneficiaries also had very limited impact, representing less than 20 eligible beneficiaries.
- **Research/Policy Recommendations:**
  1. Continue to encourage eligible health care providers in California to complete the eight hours of required buprenorphine training and apply for a waiver to prescribe buprenorphine.
  2. Continue to consider opportunities for educational outreach to providers to increase patient access to buprenorphine for medication-assisted treatment of Opioid Use Disorder.
  3. Continue to evaluate the impact of federal and state legislative efforts on the use of buprenorphine in the Medi-Cal population.
- **Clinical Recommendations:**
  1. Opioid-dependent patients should wait until they are experiencing mild to moderate opioid withdrawal before taking the first dose of buprenorphine to reduce the risk of precipitated withdrawal. Generally, buprenorphine initiation should occur at least 6 – 12 hours after the last use of heroin or other short-acting opioids, or 24 – 72 hours after the last use of long-acting opioids such as methadone.

2. Induction of buprenorphine should start with a dose of 2 – 4 mg. Dosages may be increased in increments of 2 – 4mg and doses after induction and titration should be, on average, at least 8 mg per day.
3. Health care providers should see patients frequently at the beginning of their treatment. Weekly visits (at least) are recommended until patients are determined to be stable. There is no recommended time limit for treatment.
4. Health care providers should take several actions and precautions, and develop a treatment plan when buprenorphine or methadone is used in combination with benzodiazepines or other CNS depressants.
5. As soon as a pregnant woman is diagnosed with opioid use disorder, health care providers should review and discuss the risks and benefits of each antagonist and agonist treatment option with her. Health care providers should inform her that pharmacotherapy is strongly recommended and that treatment without any pharmacotherapy is complicated by poor fetal health, high rates of return to substance use, and the consequences such as risk of overdose. For pregnant women initiating treatment, ensure the proper release forms are completed to allow communication among all health care providers involved in her care.
6. Given the potentially high number of refill visits for patients who are adherent to their buprenorphine regimen, pharmacists should ensure their pharmacy is stocked with buprenorphine and the environment is safe and welcoming.
7. Pharmacists should reach out to patients who do not pick up their refills. Pharmacists know when patients do not show up for refills and can play a vital and active role in encouraging adherence to buprenorphine therapy.
8. Pharmacists should provide the Medication Guide to patients each and every time the medicine is dispensed and discuss the risks and side effects associated with buprenorphine products, including what to do if patients experience side effects.

## 16.2016 Immunization Updates: Influenza, Meningococcal, Tdap, Hib, Rotavirus – September 2016

- **Background:** Starting in 2014, the California Medi-Cal Drug Use Review program began consolidating updates in immunization guidelines, products, and/or research into an annual summary. The 2016 summary included influenza, meningococcal disease serogroup C (MDC), pertussis, haemophilus influenzae type B (Hib), and rotavirus immunization updates.
- **Purpose:** The purpose of this biennial review is to review updates to the ACIP recommendations for influenza, MDC, pertussis, Hib, and rotavirus vaccines since the original article was published in September 2016.
- **Data Criteria and Findings:**
  1. *Influenza vaccine:* During both the 2014 – 2015 and 2015 – 2016 influenza seasons, ACIP recommended the use of live attenuated influenza vaccine (LAIV) for healthy children aged two through eight years without contraindications or precautions to the vaccine. Due to low effectiveness in the United States during those seasons, this recommendation was reversed for both the 2016 – 2017 and 2017 – 2018 seasons. However, for the 2018 – 2019 season, quadrivalent LAIV (LAIV4) was again an available option.

### Additional influenza updates specific to California:

- Influenza activity in California reached very high levels of severity during the 2017 – 2018 influenza season, increasing in early December and peaking in late-December/early-January. This timing was similar to that seen during the 2016 – 2017 influenza season and earlier than the 2012 – 2013 through 2015 – 2016 influenza seasons in the state. In California, influenza A (H3N2) viruses predominated overall, but influenza B viruses predominated from mid-February through May.
- For the 2017 – 2018 influenza season the cumulative influenza vaccination coverage estimate in California was 40.0% for all persons 6 months of age and older (down from 48.0% in 2016 – 2017), which is below the national average of 41.7%.
- In 2017, influenza and pneumonia remained the 8<sup>th</sup> most common cause of death in the United States.

- During the 2017 – 2018 influenza season, the California Department of Public Health (CDPH) received 336 reports of influenza-related deaths among persons less than 65 years of age, compared with 83 deaths during the 2014 – 2015 season, 162 deaths during the 2015 – 2016 season, and 119 deaths during the 2016 – 2017 season.
2. *Meningococcal vaccine*: At their June 2016 meeting, ACIP recommended meningococcal conjugate vaccine (serogroups A, C, W, and Y), including booster doses, for everyone with human immunodeficiency virus (HIV) infection  $\geq 2$  months of age due to growing evidence supporting an increased risk for contracting the meningococcal disease in HIV-infected people.
  3. *Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine*: There have been no new ACIP recommendations for Tdap vaccines since the original article was published in September 2016. However, a [comprehensive summary of previously published ACIP recommendations](#) was published in April 2018.
- In addition, the Immunization Branch of the CDPH published a report that assessed [barriers to prenatal Tdap among mothers of infants aged <4 months with pertussis in California during 2016](#). The report found that 1) referring pregnant women off site for Tdap is not effective, 2) infants with pertussis whose mothers were vaccinated during pregnancy had less severe disease, 3) cost and reimbursement rate were the most common reasons cited by providers for not stocking Tdap onsite; and 4) provider education is needed.
4. *Haemophilus influenzae type B (Hib) vaccine*: There have been no updates to the ACIP recommendations for Hib vaccines since the original article was published in September 2016.
  5. *Rotavirus vaccine*: There have been no updates to the ACIP recommendations for rotavirus vaccines since the original article was published in September 2016.
- **Analysis**: On August 25, 2016, the State of California Board of Pharmacy released new [regulations](#) that mandate pharmacists report vaccinations they

administer to the California Immunization Registry (CAIR) within 14 days. This information was not covered previously in the original article.

- **Limitations:** None.
- **Research/Policy Recommendations:**
  1. Continue to follow updates to immunization regulations and legislation in California.
  2. Continue to work with the CDPH on annual summaries of immunization guidelines, products, and/or research to ensure the highest priority information gets promoted through as many channels as possible.
  3. Develop targeted DUR educational outreach to providers and pharmacies, as needed, to promote vaccination according to CDC guidelines.
  4. Closely monitor surveillance reports for vaccine-preventable diseases through the CDPH website.
- **Clinical Recommendations:**
  1. All prescribers and pharmacies should review immunization status and other evidence of immunity to vaccine-preventable diseases for all patients.
  2. All health care providers should routinely encourage annual influenza vaccine for all patients 6 months of age and older.
  3. All health care providers should feel comfortable addressing myths about vaccines and vaccine-preventable diseases.
  4. Improve practice patterns to provide Tdap vaccination to all women at the earliest opportunity between 27 and 36 weeks gestation of each pregnancy by promoting on-site prenatal vaccinations, stocking clinics with Tdap vaccine, and educating providers about Tdap recommendations.



**UCSF** School of  
Pharmacy

## DUR Publications: Q1 2019

Shal Lynch, PharmD, CGP  
Health Sciences Associate Clinical Professor  
Department of Clinical Pharmacy

## DUR Publications

### February 2019: Bulletin

- [Clinical Review Update: Morphine Equivalent Daily Dose](#)

### March 2019: Alert

- [Drug Safety Communication: Updated Adverse Effects from Fluoroquinolones](#)

### April 2019: Alert

- [Drug Safety Communication: Risks From Sudden Discontinuation Of Opioids](#)

## Future Recommendations

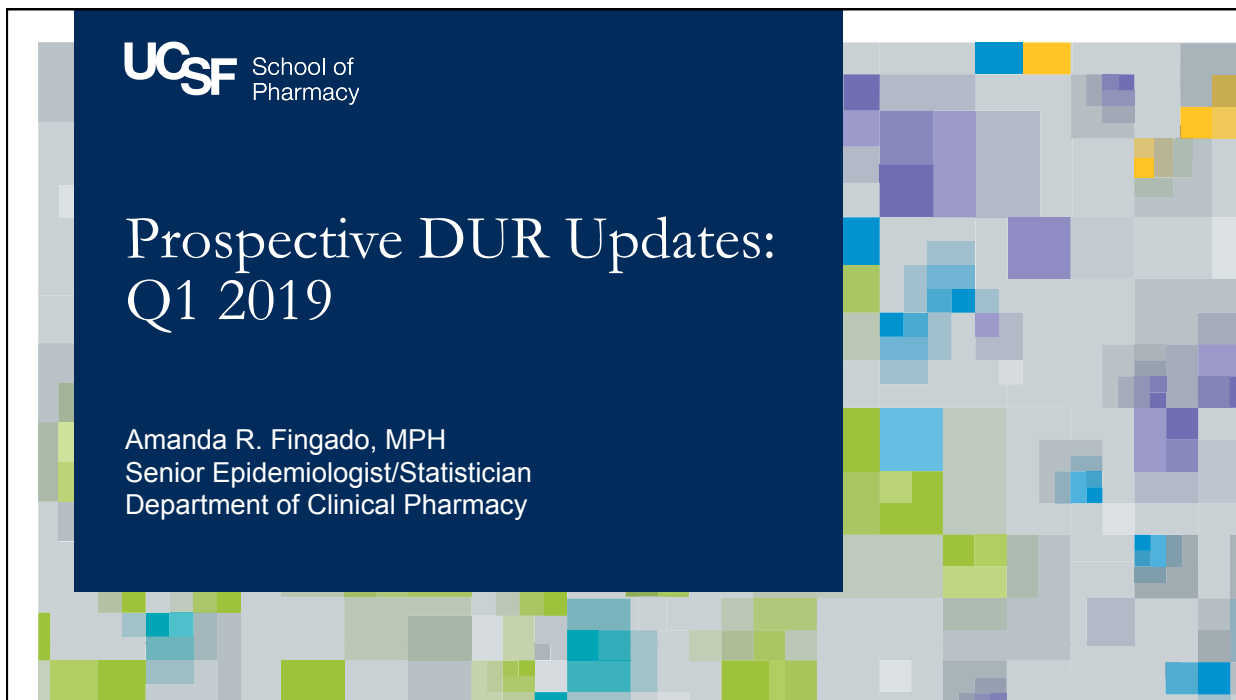
- Alerts:

- California Upgrades Immunization Registry to CAIR2

- Bulletins:

- Managing pain in population with comorbid mental health conditions
- Pharmacist furnishing of naloxone
- Pharmacist furnishing of hormonal contraception
- Hypertension medication adherence

Board recommendations?



**UCSF** School of Pharmacy

## Prospective DUR Updates: Q1 2019

Amanda R. Fingado, MPH  
Senior Epidemiologist/Statistician  
Department of Clinical Pharmacy

## Prospective DUR Updates – Q1 2019

### Topics for Discussion:

- New Generic Code Number (GCN) Alert Profiles
- Additive Toxicity (AT) Alert Update: Gabapentinoids

## New GCN Alert Profiles

### Background

- Each week new Generic Code Numbers (GCNs) are added
- Overutilization (ER), Drug-Pregnancy (PG) and Drug-Drug Interactions (DD) alerts are automatically turned on for all new GCNs
- New GCNs are reviewed weekly for additional alerts
- New GCNs with alerts turned on other than ER, PG, and DD are provided at each Board meeting for review

## New GCN Alert Profiles (cont.)

Table 1. New GCNs for Existing DUR Target Drugs: Q1 2019

Drug Description	Alerts Turned On
BENZHYDROCODONE/ACETAMINOPHEN	AT, ID, HD
CHLORPHENIRAMINE/CODEINE PHOS	AT, PA
DESOGESTREL-ETHINYL ESTRADIOL	MC, TD, ID, HD, LD
DIGOXIN, MICRONIZED	LR, HD, LD
DM/PE/ACETAMINOPH/DIPHENHYDRAM	ID, HD
ESTRADIOL	MC
ESTRADIOL/PROGESTERONE	MC, TD, ID, HD, LD
ETHYNODIOL D-ETHINYL ESTRADIOL	MC, TD, ID, HD, LD
LEVONORGESTREL-ETHIN ESTRADIOL	MC, TD, ID, HD, LD
LEVORPHANOL TARTRATE	AT
LEVOTHYROXINE SODIUM	TD, LR, ID, HD, LD
NORETHINDRONE	MC, TD, ID, HD, LD
NORETHINDRONE-ETHINYL ESTRAD	MC, TD, ID, HD, LD
NORGESTIMATE-ETHINYL ESTRADIOL	MC, TD, ID, HD, LD
NORGESTREL-ETHINYL ESTRADIOL	MC, TD, ID, HD, LD
SUFENTANIL CITRATE	AT

<b>DA</b>	Drug-Allergy
<b>MC</b>	Drug-Disease
<b>TD</b>	Therapeutic Duplication
<b>LR</b>	Late Refill
<b>AT</b>	Additive Toxicity
<b>ID</b>	Ingredient Duplication
<b>PA</b>	Drug-Age
<b>HD</b>	High Dose
<b>LD</b>	Low Dose



## Board questions/recommendations?



## AT Alert Update: Gabapentinoids

- Effective April 15, 2019, gabapentinoids were added to the list of drugs for additive toxicity (AT) alert
  - Based on side effect profile, literature review, and analysis of pharmacy claims data
- Available AT alert data for gabapentinoids will be presented at the May meeting, in order to determine initial impact and alert burden



Board questions/recommendations?



## DUR Educational Outreach: Q1 2019

Amanda R. Fingado, MPH  
Senior Epidemiologist/Statistician  
Department of Clinical Pharmacy

## DUR Educational Outreach

Topics for Discussion

- Proposal: Zolpidem
- Proposal: Opioid Use in Children < 18
- Outcomes: MEDD 2019

2 DUR Educational Outreach UCSF

## Background: Zolpidem Letter

- FDA recommends lower initial doses of zolpidem in females due to lower clearance rates leading to higher concentrations and increased risk for next-day impairment and other adverse events.
  - Recommended initial dose of immediate-release zolpidem products is 5 mg for women and either 5 mg/10 mg for men
  - Recommended initial dose of extended-release zolpidem products is 6.25 mg for women and either 6.25/12.5 mg for men

3 DUR Educational Outreach UCSF

## Objective: Zolpidem Letter

- To determine whether there was inappropriate use of zolpidem products based on FDA warnings that female patients have lower clearance rates than males.

4 DUR Educational Outreach UCSF

## Methods: Zolpidem Letter

- Top ~100 prescribers of zolpidem in the Medi-Cal fee-for-service population will receive letter
- Letter will include reference data, including the following:
  - Overall percentage of initial zolpidem prescriptions exceeding the recommended initial dosage limits, stratified by gender
  - Provider-specific percentages
  - Outliers will be identified as such within the letter

5 DUR Educational Outreach UCSF

## Outcomes: Zolpidem Letter

- Primary:
  - Provider-specific percentages of initial zolpidem prescriptions exceeding the recommended initial dosage limits, stratified by gender within 12 months following the mailing
- Secondary:
  - Total initial zolpidem prescriptions within 12 months following the mailing

6 DUR Educational Outreach UCSF

## Board recommendations?

7 OUR Educational Outreach



## Background: Opioid Use in Children < 18

- April 20, 2017: FDA adds *Contraindication* to the labels of all prescription medications containing codeine and tramadol
  - Neither should be used to treat pain or cough in children < 12 due to risk of serious side effects, including death
  - Use should be limited in adolescents between 12 – 18 years of age
- January 11, 2018: FDA restricts prescription opioid cough and cold medicines for patients <18 years

8 OUR Educational Outreach



## Objectives: Opioid/Children Letter

- To inform health care providers and patients of the serious risks attributed to prescribing selected opioids to patients <18 years

9 OUR Educational Outreach



## Methods: Opioid/Children Letter

- Inclusion criteria:
  - During the measurement year had at least one paid claim for a selected opioid medication in a child or adolescent < 18 years of age
- Exclusion criteria:
  - Practice locations including SNF, ICF, home health, hospice
  - Diagnostic codes indicating palliative care or cancer treatment

10 OUR Educational Outreach



## Outcomes: Opioid/Children Letter

- Primary:
  - Total continuously-eligible beneficiaries < 18 years of age with a paid claim for selected opioids within the 12 months following the mailing

11 OUR Educational Outreach



## Board recommendations?

12 OUR Educational Outreach



## Outcomes: MEDD 2019 - 1

### Background:

- In 2016, DUR program sent letters/profiles to 134 prescribers of 155 beneficiaries with individual paid claims > 120 mg MEDD
- Outcomes:
  - Response rate 23% with 97% rating info as "useful" or "very useful"
  - 40% of beneficiaries ↓ total days with cumulative MEDD > 120 mg
  - 20% of beneficiaries ≥1 paid claim for MAT
- In November 2017 the Board recommended repeat of mailing

13 DUR Educational Outreach



## Outcomes: MEDD 2019 - 2

### Objectives:

- To improve the quality of pain treatment among non-cancer, non-hospice Medi-Cal fee-for-service beneficiaries at increased risk of opioid overdose.

14 DUR Educational Outreach



## Outcomes: MEDD 2019 - 3

### Methods:

- Study population included 87 Medi-Cal FFS beneficiaries with at least 1 paid claim > 120 mg MEDD since January 1, 2019
  - 26 (31%) had a paid claim for naloxone since January 1, 2019
  - Furnished by pharmacists (n = 9) and ordered by prescribers (n = 17)
- Letters included patient profiles, updated Medi-Cal DUR MEDD article, naloxone handout, and provider surveys
- Letters mailed to 85 prescribers on April 26, 2019

15 DUR Educational Outreach



## Outcomes: MEDD 2019 - 4

### Outcomes:

- Primary outcome
  - The percentage of the continuously-eligible study population with a paid claim exceeding > 120 mg MEDD in the 6-month period following the mailing of the intervention letter

16 DUR Educational Outreach



## Outcomes: MEDD 2019 - 5

### Outcomes:

- Secondary outcomes
  - % of the continuously-eligible study population with at least 1 paid claim for MAT in the 6-month period following the mailing
  - % of the continuously-eligible study population with hospital or emergency department visits due to opioid overdose in the 6-month period following the mailing
  - % of the continuously-eligible study population with at least 1 paid claim for naloxone in the 6-month period following the mailing

17 DUR Educational Outreach



Board recommendations?

18 DUR Educational Outreach



## Future Topics



### DUR Educational Outreach to Pharmacies/Providers

- Updated ACOG guidelines for postpartum pain
- Updated NAMS guidelines for hormone replacement therapy
- Updated ADA opioid guidelines to dentists
- Oseltamivir or zanamivir paid claims + influenza vaccine
- Concomitant gabapentin/opioids
- Statin use with cardiovascular disease
- Chronic use of PPIs
- Chronic use of temazepam/zolpidem

19 DUR Educational Outreach





## Global Medi-Cal Drug Utilization Review Board Pharmacy Update

Pauline Chan, R.Ph., MBA  
May 21, 2019



### Topics

1. Policy: AB1114 Implementation
2. DUR goals, priority areas and related measures
3. Opioids Safety Toolkit for Health Plans
4. CURES 2.0
5. Academic Detailing
6. Addressing Complex Drug Regimens
7. SUPPORT Act
8. FFY 2018 DUR Annual Report



Global Medi-Cal DUR Board Meeting 05-21-19




### AB 1114 Implementation

- Pharmacists Services Benefit (AB1114)
  - Fee-For-Service (FFS) implemented on April 1, 2019
  - Managed Care Health Plans to implement by December 31, 2019
  - Frequently Asked Questions (FAQ) to be posted on the Medi-Cal Website when completed




Global Medi-Cal DUR Board Meeting  
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## DUR Priority Areas Measures

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- Aligning DUR goals with Medicaid Health Care Quality Measures
  - Medication related measures
- [2019 Child Core Set](#)
- [2019 Adult Core Set](#)



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## Opioid Safety Toolkit

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California Health Care Foundation's [Opioid Safety Toolkit](#)

- Tools and tactics for health plans, include best practices and success stories
  - Examples of best “Pharmacy Benefits” practices:
    - Kaiser Permanente So. California – Emergency Department Guidelines
    - LA Care – Retrospective DUR
    - Partnership Health Plan of California – identify high users and high risk patients



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## CURES 2.0

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- [CURES 2.0](#)
- Refer to the [CURES Mandatory Use](#) reference sheet, [CURES Advisory Memo](#) and the [Medical Board of California's FAQs](#) for additional information regarding the CURES consultation requirement
- For questions, contact the CURES Program at [CURES@doj.ca.gov](mailto:CURES@doj.ca.gov) or (916) 210-3187



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### Academic Detailing

- [NaRCAD e-news, Spring 2019 edition](#)
  - Clinicians as Champions
  - Anchoring an AD Team: Building Bonds
- Opioid Safety Academic Detailing Training
  - [July 2019 Training](#)



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### Complex Drug Regimens

- [Complex Drug Regimens](#)
- Centers for Health Care Strategies (CHCS) Webinar to address medication complexity through community-based strategies and partnerships



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### CMS Guidance

- [SUPPORT Act](#)
  - DUR Minimum Requirements
- CMS to provide further guidance in upcoming months



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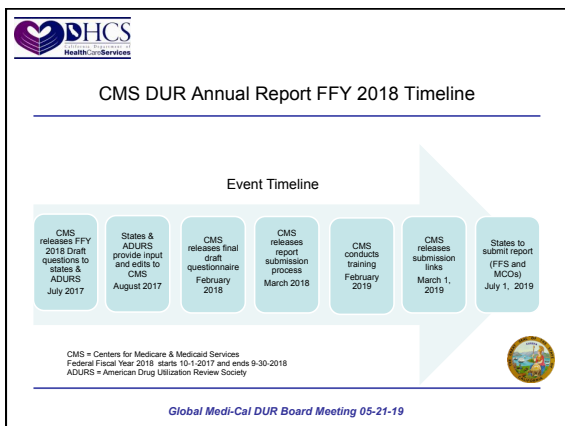
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**Questions?**

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